INSTRUCTIONS FOR COMPLETING THE NON-COVERED REPORT OF OCCUPATIONAL INJURY OR ILLNESS (DWC FORM-7)

All on-the-job injuries resulting in more than one day lost time, all occupational diseases of which the employer has knowledge (regardless of lost time), and all fatalities occurring during the calendar month must be reported. If no such injuries, diseases or fatalities have occurred during the calendar month, no report is required. Lost time begins the day after the day of the injury. For example, an employee injured on 1-1-92 who returns to work on 1-4-92 would have a lost time of 2 days since the day of the injury does not count, nor does the day the employee returned.

Use as many supplemental sheets as needed (form can be reproduced). The first sheet must have all Employer as well as Injury Data completed. Subsequent sheets must have the Employer's Business Name, Federal Employer Identification Number, and Injury Data completed.

The completed form must be personally delivered or mailed **not later than the seventh day** of the following month to the:

Texas Department of Insurance
Division Workers' Compensation
7551 Metro Center Drive, Suite 100
Austin, Texas 78744

Month - Enter the calendar month. **Year** - Enter the calendar year.

Employer Data

ITEM: INSTRUCTIONS:

1. **Employer's Business Name** - Use employer DBA (Doing Business As). If employer does not have a DBA, use other business name.
2. **Federal Employer ID No.** - (FEIN) Obtain this number from financial or tax account records. If the employer has more than one FEIN, use a separate DWC FORM-7 for each separate FEIN.
3. **Telephone Number** - Business telephone number of the individual completing the report.
4. **Employer's Business Mailing Address** - Give the street address and post office box number (if applicable).
5. **City, County, State, Zip** - Name of County must be included.
6. **Employer's Representative** - Print or type name and title of individual completing the report.
7. **Employer's Representative's Signature** - Signature of Employer's Representative certifying the information provided on the form is correct.
8. **Employer's Six-Digit NAICS Codes With Employment - List all 6-digit NAICS Codes which the employer uses with the FEIN specified in block 1 only.** If unknown, consult Texas Workforce Commission Form C-3, Employer's Quarterly Report, block 5, for this information. Give the highest employment figure for each NAICS Code for the month of the report. Employment means all employees on your payroll whether full-time, part-time, temporary, or permanent. Use a separate sheet for information that does not fit in the block.**

Injury Data

9. **Employee's Name** - List the full name of the individual who suffered an injury, occupational disease, or fatality.
10. **Date of Injury/Illness** - Enter the date the injury occurred or the date the employer first had knowledge of the occupational disease.
11. **Employee 6-Digit NAICS** - List the 6-digit NAICS Code of the activity that the employee was engaged in at the time of the injury/illness. The code listed must be one of the 6-digit NAICS Code numbers reported by the employer in block 8. If NAICS Codes are unknown, consult Texas Workforce Commission (TWC) Form C-3, Employer's Quarterly Report, block 5, for this information.**
12. **Equipment** - List equipment (if any) involved in the injury.
13. **Nature of INJ/Ill** - Enter the type of injury/illness. For example: cut, burn, bruise, fracture, sprain, strain, chemical burn, dermatitis, asbestosis, silicosis. Use most serious condition if multiple injuries.
14. **Body Part(s) Affected** - List the most seriously injured part(s). for example: head, hand, torso, leg, back, ankle, wrist, lungs, skin, eyes.
15. **Social Security Number** - Enter the Employee's Social Security Number.
16. **Sex** - Check appropriate block. Information as to the sex of the employee will be maintained for non-discriminatory statistical use.
17. **DOB** - DATE OF BIRTH - Enter month, day and year.
18. **Race/Ethnic Identification** - Check appropriate block. Information as to the race/ethnicity of the Employee will be maintained for non-discriminatory statistical use.
    NOTE: "HISPANIC', while not a race identification, is included as a separate race/ethnic category. Do not include Hispanic under "white" or "black."
19. **Cause of Injury** - Give the most probable cause of injury/illness. Example: Overexertion due to lifting or pushing; caught between; slip; trip; fall.
20. **Location of Injury** - Check block A if injury occurred at primary business location. Check block B if injury occurred at on-site job location. Check block C if injury occurred while traveling between work locations.
21. **Occupation** - List the type of work the injured individual was engaged in at the time of the injury/illness. For example: carpenter, pipe fitter.
22. **Description of Incident** - Give a short narrative of how the incident occurred. For example, "While painting house, fell off ladder and fractured arm.
23. **Lost Time** - If the employee lost more than one day after the date of the injury but less than 8 days, check > 1 Day - 7 Days. If the employee lost 8 or more days check the 8 Days or More block.
24. **Occupational Disease** - If employee suffered an Occupational Disease, check "YES", if not, check "NO."
25. **Fatality** - Did the injury/illness result in the death of the employee? If yes, check "YES" and list date of death. If no, check "NO."
26. **DO NOT WRITE IN THIS BLOCK. IT IS RESERVED FOR DWC USE ONLY.**

** For companies that do not report to TWC, NAICS code can be found in the North American Industry Classification System published by the National Technical Information Service, 5285 Port Royal Road, Springfield, Virginia 22161, e-mail: info@ntis.fedworld.gov.

DWC FORM - 7
(Non-covered Employer's Report of Occupational Injury or Illness)

Certain non-covered employers, described below, are required to file reports with DWC using DWC FORM-7, Non-covered Employer's Report of Occupational Injury or Illness. Employers must list on the DWC FORM-7 all fatalities, all occupational diseases of which the employer had knowledge (even if there is no lost time) and all on-the-job injuries resulting in more than one day's absence from work for the injured employee. The completed DWC FORM-7 reporting all such injuries that have occurred during a calendar month must be filed no later than the 7th day of the following month.

Non-covered employers are required to file this form if they have more than 4 employees*

* All employees are counted for these requirements unless they are domestic workers, or casual workers engaged in employment incidental to a personal residence, or are certain farm and ranch workers, or are workers covered by a method of compensation established under federal law.

The DWC FORM -7 is considered filed when personally delivered or postmarked. Send the DWC FORM-7 and the DWC FORM-7 Supplemental to the Texas Department of Insurance, Division of Workers' Compensation, Customer Services, 7551 Metro Center Drive, Suite 100, Austin, Texas 78744.

(*Rule 160.2 Non-Subscribing Employer's Report of Injury)*

TEXAS DEPARTMENT OF INSURANCE,
DIVISION OF WORKERS' COMPENSATION
Customer Services
7551 Metro Center Drive, Suite 100
Austin, Texas 78744

NON-COVERED EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

REPORT FOR MONTH OF: _____ YEAR: _____

EMPLOYER DATA

1.Employer's Business Name	2. Federal Employer ID No.	3. Telephone No.
4.Employer's Business Mailing Address (Street or P.O. Box)		
5. City County State Zip		
6. Employer's Representative (Print/Type Name and Title of Person Completing Form)	7. Employer's Representative's Signature	

Last First MI I certify the information provided is correct Date (m-d-y)

8 NAICS CODES /Employment	
NAICS Codes	NAICS Employment

INJURY DATA

1 Employee's Name
Last First MI

10. Date of Injury/Illness (m-d-y)	11. Employee 6 Digit NAICS code	12. Equipment	13. Nature of INJ/ILL	14. Body Part(s) Affected

15. Social Security Number

16. Sex ☐ M ☐ F

17. DOB (m-d-y)

18. Race/Ethnic Identification
☐ White (not of Hispanic origin) ☐ Hispanic ☐ Asian or Pacific Islander
☐ Black (not of Hispanic origin) ☐ American Indian or Alaskan Native

22. Description of Incident

23. Lost Time
☐ > 1 Day - 7 Days
☐ 8 Days or More

24. Occupational Disease ☐ YES ☐ NO

19. Cause of Injury

20. Location of Injury (see instructions) ☐ A ☐ B ☐ C

21. Employee's Occupation

21a. Hourly Wage

26. DWC USE ONLY

OCC NAT BOD SRCE ACCDT AOS

25. Fatality ☐ YES ☐ NO
Date (m-d-y)

2 Employee's Name
Last First MI

10. Date of Injury/Illness (m-d-y)	11. Employee 6 Digit NAICS code	12. Equipment	13. Nature of INJ/ILL	14. Body Part(s) Affected

15. Social Security Number

16. Sex ☐ M ☐ F

17. DOB (m-d-y)

18. Race/Ethnic Identification
☐ White (not of Hispanic origin) ☐ Hispanic ☐ Asian or Pacific Islander
☐ Black (not of Hispanic origin) ☐ American Indian or Alaskan Native

22. Description of Incident

23. Lost Time
☐ > 1 Day – 7 days
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24. Occupational Disease ☐ YES ☐ NO

19. Cause of Injury

20. Location of Injury (see instructions) ☐ A ☐ B ☐ C

21. Employee's Occupation

21a. Hourly Wage

26. DWC USE ONLY

OCC NAT BOD SRCE ACCDT AOS

25. Fatality ☐ YES ☐ NO
Date (m-d-y)

Commission date stamp