TDI Division of Workers' Compensation

PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

DWC Claim#
Carrier Claim#

Send the completed form to the address above or fax to 512-804-4378.

Employee's Claim for Compensation for a Work-Related Injury or Occupational Disease (DWC Form-041)

Claim for workers' compensation must be filed by the injured employee or by a person acting on the injured employee's behalf **within one year** of the date of injury or within one year from the date the injured employee knew or should have known the injury or disease may be work-related.

I. INJURED EMPLOYEE INFORMATION

Name (First, Middle, Last)	**Social Security Number**	**Date of birth** (mm / dd / yyyy)
Address (street, city/town, state, zip code, county, country)		
Phone Number	**E-Mail address**	**Sex** ☐Male ☐Female
Race / Ethnicity ☐White, not of Hispanic Origin ☐ Black, not of Hispanic Origin ☐Hispanic ☐ Asian or Pacific Islander		
Do you speak English? ☐ Yes ☐ No If no, specify language		
Marital status ☐ Married ☐ Widowed ☐Separated ☐Single ☐Divorced		
Do you have an attorney or other representation? ☐Yes ☐No **If yes, name of representative**		
Have you returned to work? ☐Yes ☐No	**If returned to work, date returned** (mm/dd/yyyy)	**Work status** ☐Regular ☐Restricted
Occupation at time of injury		**Date of hire** (mm / dd / yyyy)
Hired or recruited in Texas ☐ Yes ☐ No	**Pre-tax wages** (at the time of injury) $	☐hourly ☐ weekly ☐monthly

II. INJURY INFORMATION

I am reporting an ☐ injury **or** ☐ occupational disease	**Date of injury** (mm / dd / yyyy)	**Time of injury**
First work day missed (mm / dd / yyyy)	**Date injury was reported to the employer** (mm / dd / yyyy)	
Where did the injury occur? County	**State**	**Country**
If accident occurred outside of Texas, on what date did you leave Texas? (mm/dd/yyyy)		
Witness(es) to the injury (list by name)		
Describe cause of injury or occupational disease, including how it is work related		
Body part(s) affected by the injury		
If injury is the result of an occupational disease: **1. On what date was the employee last exposed to the cause of the occupational disease?** (mm / dd / yyyy) **2. When did you first know occupational disease was work related?** (mm / dd / yyyy)		

III. EMPLOYER INFORMATION (at the time of injury)

Employer name	**Employer address** (street, city/town, state, zip code, county, country)
Employer phone number	**Supervisor name**

IV. DOCTOR INFORMATION

Name of treating doctor	**Phone number**
Address (street, city/town, state, zip code)	
Name of workers' compensation health care network, if any	

Signature of injured employee or person filling out this form on behalf of injured employee **Date**

Printed name of injured employee or person filling out form on behalf of injured employee

Information about Employee's Claim for Compensation for a Work-Related Injury or Occupational Disease (DWC Form-041)

A claim for Workers' Compensation benefits must be filed with the Division of Workers' Compensation (Division) by the injured employee (you), or by a person acting on the injured employee's (your) behalf within *one year* of the injury or within *one year* from the date you knew or should have known the injury or disease may be work related; UNLESS good cause exists for the failure to timely file a claim, or the employer or the employer's insurance carrier does not contest the claim.

Upon receipt of your completed DWC Form-041, or other notice of your injury, the Division will create a claim and establish a DWC claim number for you, and the Division will mail information regarding workers' compensation in Texas to you. The Division will also notify your employer and the employer's workers' compensation insurance carrier.

SPECIAL INSTRUCTIONS AND INFORMATION FOR COMPLETING THE DWC Form-041

General Instructions

- **Complete all boxes in the DWC Form-041**.
- If you have questions about completing this form, please call your local Division Field Office at 1-800-252-7031.

Injured Employee Information

- Work Status information
  - If you have returned to your regular job and you are performing the same duties as you were before your injury, check the "Regular" box.
  - If you have been released to work with restrictions by a doctor, check "Restricted."

Injury Information

- An *injury* is damage to your body that was caused by a single incident, accident, or event.
- An *occupational disease* is an illness or injury related to or caused by the work you do, and may include injuries to your body that are the result of repetitive activities you performed on the job over a period of time.

Employer Information

- Provide information about your employer at the time you were injured.

Doctor Information

- If you already have a workers' compensation treating doctor, provide the name and address of the doctor.
- If you are covered under a workers' compensation healthcare network, provide the name of the network.

Contacting Texas Department of Insurance, Division of Workers' Compensation

If you have questions about filling out this form or workers' compensation in Texas, please call your local Division Field Office at 1-800-252-7031.

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); and
- have DWC correct information that is incorrect (Government Code Section 559.004).

For more information, contact DWCLegalServices@tdi.texas.gov or refer to the Corrections Procedure section at www.tdi.texas.gov/commissioner/legal/lccorprc.html.