



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

Form section I containing fields for Name, Social Security Number, Date of birth, Address, Phone Number, E-Mail address, Sex, Race / Ethnicity, Do you speak English?, Marital status, Do you have an attorney or other representation?, Have you returned to work?, Occupation at time of injury, Date of hire, and Pre-tax wages.

II. INJURY INFORMATION

Form section II containing fields for injury type, Date of injury, Time of injury, First work day missed, Date injury was reported to the employer, Where did the injury occur?, If accident occurred outside of Texas, Witness(es) to the injury, Describe cause of injury or occupational disease, Body part(s) affected by the injury, and questions about occupational disease.

III. EMPLOYER INFORMATION (at the time of injury)

Form section III containing fields for Employer name, Employer address, Employer phone number, and Supervisor name.

IV. DOCTOR INFORMATION

Form section IV containing fields for Name of treating doctor, Phone number, Address, and 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](mailto:DWCLegalServices@tdi.texas.gov) or refer to the Corrections Procedure section at [www.tdi.texas.gov/commissioner/legal/lccorprc.html](http://www.tdi.texas.gov/commissioner/legal/lccorprc.html).