Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • MS-96
Austin, TX 78744-1645
(800) 372-7713 phone • (512) 804-4146 fax

Employer's Report of Non-covered Employee's Occupational Injury or Disease

Type or print in black ink

☐ **Non-subscribing Employer**
☐ **Subscribing Employer - Employee Waived Workers' Compensation Insurance Coverage**

I. EMPLOYER INFORMATION

1. Employer Business Name			
2. Reporting Period (mm/yyyy)	**3. Number of Injured Employees Included on This Report**		
4. Employer Business Mailing Address (Street or PO Box, City, County, State, Zip Code)		**5. Provide the following:**	
		NAICS Codes	**NAICS Employment**
6. Employer Physical Address (Street, City, State, Zip Code)			
7. Employer Phone Number			
8. Federal Employer ID Number			
9. Name of Person Completing Form			
10. Phone Number of Person Completing Form			
11. Title of Person Completing Form			
12. Signature of Person Completing Form		**13. Date of Signature** (mm/dd/yyyy)	

II. INJURED EMPLOYEE INFORMATION / INJURY DATA

14. Employee Name (First, Middle, Last)		**15. Employee's SSN**
16. Date of Birth (mm/dd/yyyy)	**17. Date of Hire** (mm/dd/yyyy)	**18. Sex** ☐ Male ☐ Female
19. Occupation	**20. Hourly Wage**	**21. Employee NAICS Code**
22. Race/Ethnic Identification ☐ White ☐ Black ☐ Hispanic ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native ☐ Other (specify)		

For TDI-DWC Use Only

23. Address Where Injury/Occupational Disease Occurred (Street, City, State, Zip Code)	
24. Type of Location Where Injury/Occupational Disease Occurred ☐ Primary Business Location ☐ On-site Job Location ☐ Traveling between Job Locations	
25. Date of Injury/Occupational Disease (mm/dd/yyyy)	**26. Date Reported By Employee** (mm/dd/yyyy)
27. Return to Work ☐ Date or ☐ Expected Date (mm/dd/yyyy)	
28. Reported Cause of Injury	
29. Nature of Injury/Occupational Disease	
30. Equipment Involved in the Injury (if any)	
31. Body Part(s) Affected	
32. First Day of Absence from Work (mm/dd/yyyy)	**33. Number of Days Absent from Work** ☐ 1 Day or Less ☐ >1 Day – 7 Days ☐ 8 Days or More
34. Occupational Disease ☐ Yes ☐ No	**35. Fatality** ☐ Yes ☐ No If Yes, provide date (mm/dd/yyyy)
36. Description of Incident	

NOTE[1]: Title 28 Texas Administrative Code, Chapter 160 requires employers to report work-related deaths, on-the-job injuries and occupational diseases in the form and manner required by TDI-DWC. The social security number may be used to identify the injured employee.

NOTE[2]: With few exceptions, upon your request, you are entitled to be informed about information TDI-DWC collects about you; receive and review the information (Government Code, §§552.021 and 552.023); and have TDI-DWC correct information that is incorrect (Government Code, §559.004)

Employer's Name: Employer's FEIN:	For TDI-DWC Use Only

Injury Data for Additional Injured Employee(s)
(reproduce this page, if necessary)

Employer Business Name	
Employer FEIN	**Reporting Period** (mm/yyyy)

II. INJURED EMPLOYEE INFORMATION / INJURY DATA

14. Employee Name (First, Middle, Last)		**15. Employee's SSN**
16. Date of Birth (mm/dd/yyyy)	**17. Date of Hire** (mm/dd/yyyy)	**18. Sex** ☐ Male ☐ Female
19. Occupation	**20. Hourly Wage**	**21. Employee NAICS Code**

22. Race/Ethnic Identification
☐ White ☐ Black ☐ Hispanic ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native
☐ Other (specify)

23. Address Where Injury/Occupational Disease Occurred (Street, City, State, Zip Code)

24. Type of Location Where Injury/Occupational Disease Occurred
☐ Primary Business Location ☐ On-site Job Location ☐ Traveling between Job Locations

25. Date of Injury/Occupational Disease (mm/dd/yyyy)	**26. Date Reported By Employee** (mm/dd/yyyy)

27. Return to Work ☐ Date or ☐ Expected Date (mm/dd/yyyy)

28. Reported Cause of Injury

29. Nature of Injury/Occupational Disease

30. Equipment Involved in the Injury (if any)

31. Body Part(s) Affected

32. First Day of Absence from Work (mm/dd/yyyy)	**33. Number of Days Absent from Work** ☐ 1 Day or Less ☐ >1 Day – 7 Days ☐ 8 Days or More
34. Occupational Disease ☐ Yes ☐ No	**35. Fatality** ☐ Yes ☐ No If Yes, provide date (mm/dd/yyyy)

36. Description of Incident

For TDI-DWC Use Only

Frequently Asked Questions
Employer's Report of Non-covered Employee's Occupational Injury or Disease (DWC Form-007)

Which employers are required to report on-the-job injuries, occupational diseases, and work-related deaths on the DWC Form-007?

The following employers are required to file the DWC Form-007:

- An employer that **does not have** workers' compensation insurance coverage (non-subscriber) and **employs five or more employees who are not exempt** from workers' compensation insurance coverage must file the DWC Form-007 to report all on-the-job injuries and occupational diseases. Examples of exempt employees include certain domestic workers, and certain farm and ranch workers.
- An employer that **has** workers' compensation insurance coverage must file the DWC Form-007 to report an on-the-job injury or occupational disease for an **employee who has waived** workers' compensation insurance coverage in accordance with Texas Labor Code §406.034.

Failure to file the form may subject the employer to administrative penalties.

What do I do if I need to report more than two injured employees?
Copy page three of the form as many times as necessary for reporting additional injured employees.

When do I file the DWC Form-007?
The form must be filed not later than the 7th day of the month following the month in which:

- a work-related death occurred,
- an employee was absent from work for more than one day* as a result of an on-the-job injury; or
- the employer acquired knowledge of an occupational disease.

*Do not count the day of the injury or the day the injured employee returned to work when calculating the number of days absent from work.

NOTE: If no such deaths, injuries, or diseases occurred during a calendar month, no report is required for that month.

Are any fields on the DWC Form-007 optional?
No, all applicable fields must be completed each time the DWC Form-007 is filed.

How do I file the DWC Form-007?
Submit the DWC Form-007 to the Texas Department of Insurance, Division of Workers' Compensation (TDI-DWC) by:

- faxing the form to (512) 804-4146; or
- mailing the form to the address listed at the top of the form.

Instructions for Completing Specific Items

Box 5: Employer NAICS Codes*/Employment
List all six-digit NAICS Codes which the employer uses with the FEIN specified in Box 8. Provide 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. Attach additional pages, if necessary.

Box 21: Employee NAICS Code*
List the six-digit NAICS Code of the activity that the employee was engaged in at the time of the injury or disease. The code listed must be one of the six-digit NAICS Code numbers reported in Box 5.

Box 22: Race/Ethnic Identification
Check appropriate box and provide requested information, if applicable. 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".

Box 28: Reported Cause of Injury
Enter the most probable cause of the injury or disease. Examples: overexertion due to lifting or pushing, caught between, slip, trip, fall.

Box 29: Nature of Injury/Occupational Disease
Enter the type of injury or occupational disease. Examples: cut, burn, bruise, fracture, sprain, strain, chemical burn, dermatitis, asbestosis, silicosis. For multiple injuries, use most serious.

Box 33: Number of Days Absent from Work

- *Occupational disease*: Must be reported regardless of the number of days the employee is absent from work. Check the appropriate box, including *1 Day or Less*.
- *On-the-job injury*: Must be reported only if the employee is absent from work for more than one day. Do not check *1 Day or Less*.

Box 36: Description of Incident
Provide a short narrative of how the incident occurred. Example: While painting house, fell off ladder and fractured arm.

*Information on NAICS Codes can be found on the United States Census Bureau website at www.census.gov/eos/www/naics. NAICS Codes can also be obtained from 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.