

DWC FORM-41
(WORKER'S OR BENEFICIARY'S NOTICE OF INJURY OR
OCCUPATIONAL DISEASE AND CLAIM FOR COMPENSATION)

The Texas Workers' Compensation Law says that you or a person acting on your behalf must file with the Texas Department of Insurance, Division of Workers' Compensation a claim for compensation for your injury **within one year** of the date on which it happened. If your claim is for an *occupational disease*, you must file a claim **within one year** from the date you knew or should have known the disease may be related to your work.

The DWC FORM-41 identifies the injured worker and the employer and gives basic information about the worker's injury or illness.

The notice of claim is considered filed when personally delivered or mailed to the Division. It may be delivered or mailed to the field office handling the claim or to the Texas Department of Insurance, Division of Workers' Compensation, 7551 Metro Center Drive, Suite 100, Austin, Texas 78744.

This form is also available in Spanish/ El formulario también está disponible en Español.

[Texas Workers' Compensation Act, Texas Labor Code, Section 409.003, Claim for Compensation; Section 409.004, Failure to File Claim for Compensation; Rule 122.2, Injured Employee's Claim for Compensation]



CLAIM #

Section V. Witness Information (if applicable)

30a1. Last Name 1	30a2. First Name 1	30a3. Middle Name 1	30a4. Name Suffix 1
30b1. Last Name 2	30b2. First Name 2	30b3. Middle Name 2	30b4. Name Suffix 2
30c1. Last Name 3	30c2. First Name 3	30c3. Middle Name 3	30c4. Name Suffix 3

Section VI. Claim Employer Information

31. Employer's (Company) Name

32a. Address Line 1 32b. Address Line 2

32c. City/Town 32d. State 32e. ZIP/Postal Code 32f. County

32g. State/Province/Region (non USA only) 32h. Country 33a. Phone Type
 Home Business Cell

33b. Phone Country Code (non USA) 33c. Phone Area Code (USA) 33d. Phone Number 33e. Phone Extension 34a. Fax Country Code (non USA) 34b. Fax Area Code (USA) 34c. Fax Number

35a. Supervisor's Last Name 35b. Supervisor's First Name

Section VII. Worksite Location of Injury (if different from Section VI)

36. Business Name 37a. Address Line 1

37b. Address Line 2 37c. City 37d. State

37e. ZIP/Postal Code 37f. County 37g. State/Province/Region (non USA only)

37h. Country 37i. County, if incident occurred outside of Texas 38. Date left Texas (mm/dd/yyyy) If incident occurred outside of Texas

Section VIII. Occupation and Wage Details

39. Occupation at time of injury 40. Date of Hire (mm/dd/yyyy) 41. Hired or recruited in Texas? 42. Date started this position (mm/dd/yyyy)

43. Pay period
 Daily Weekly Bi-Weekly Monthly

44. Gross wages per pay period 45. Hourly Rate 46. Hours worked 47. Days worked 48. Routinely worked overtime?
 Yes No

49. Was injured worker provided health insurance meals, rent laundry, fuel or other items, which can be estimated in money?
 Yes No

49a. If yes, estimated money value 49b. How often was benefit provided?
 Daily Weekly Bi-Weekly Monthly

50. Did injured worker have a second job at the time of injury?
 Yes No

If the answer to question 50 is Yes, you must complete the following section.

Section IX. Non-claim Employer Information

51. Employer's (Company) Name

52a. Address Line 1 52b. Address Line 2

52c. City/Town 52d. State 52e. ZIP/Postal Code 52f. County

52g. State/Province/Region (non USA only) 52h. Country

53a. Employer Contact Last Name 53b. Employer Contact First Name 54a. Phone Type
 Home Business Cell

54b. Phone Country Code (Non USA) 54c. Phone Area Code (USA) 54d. Phone Number 54e. Phone Extension 55. Are you experiencing a loss of wages from the second job? Yes No 56. If the answer to the previous question is Yes what is the weekly loss?



CLAIM #

Section X. Treating Doctor Information			
57a. Last Name <input type="text"/>		57b. First Name <input type="text"/>	
58. Business Name <input type="text"/>		57c. Name Suffix <input type="text"/>	
59b. Address Line 2 <input type="text"/>		59a. Address Line 1 <input type="text"/>	
59e. ZIP/Postal Code <input type="text"/>		59c. City/Town <input type="text"/>	59d. State <input type="text"/>
59f. County <input type="text"/>	59g. State/Province/Region (non USA only) <input type="text"/>		
59h. Country <input type="text"/>		60a. Phone Type <input type="radio"/> Home <input type="radio"/> Business <input type="radio"/> Cell	60b. Phone Country Code (non USA) <input type="text"/>
60c. Phone Area Code (USA) <input type="text"/>	60d. Phone Number <input type="text"/>	60e. Phone Extension <input type="text"/>	

Section XI. Representative Information			
61. Do you have an attorney or other Representative? <input type="radio"/> Yes <input type="radio"/> No	62a. Representative's Last Name <input type="text"/>		62b. Representative's First Name <input type="text"/>
			60c. Name Suffix <input type="text"/>
63. Relationship to Injured Worker <input type="radio"/> Attorney <input type="radio"/> Union Representative <input type="radio"/> Family Member <input type="radio"/> Friend <input type="radio"/> Other	If other, Specify <input type="text"/>		
64. Business Name <input type="text"/>		65a. Address Line 1 <input type="text"/>	
65b. Address Line 2 <input type="text"/>		65c. City/Town <input type="text"/>	65d. State <input type="text"/>
65e. ZIP/Postal Code <input type="text"/>		65f. County <input type="text"/>	
65g. State/Province/Region (non USA only) <input type="text"/>			
65h. Country <input type="text"/>		66a. Phone Type <input type="radio"/> Home <input type="radio"/> Business <input type="radio"/> Cell	66b. Phone Country Code (non USA) <input type="text"/>
66c. Phone Area Code (USA) <input type="text"/>	66d. Phone Number <input type="text"/>	66e. Phone Extension <input type="text"/>	
67. Date representation began (mm/dd/yyyy) <input type="text"/>			

Signature of the Injured Worker or Person Acting on Behalf of the Injured Worker

Signature _____ Date _____

Signature of Witness _____ Date _____
(Only when signed with an X)

If you are acting on behalf of the injured worker, complete the section below.

Section XII. Person Acting on Behalf of the Injured Worker
68. Name of Person Filing Form <input type="text"/>



INSTRUCTIONS FOR FILING YOUR WORKER'S OR BENEFICIARY'S NOTICE OF INJURY OR
OCCUPATIONAL DISEASE AND CLAIM FOR COMPENSATION (DWC FORM-41)

Special Instructions for Certain Requested Information – continued

- 90 - Other Than Physical Cause of Injury
- 94 - Repetitive Motion - callous, blister, etc.
- 96 - Terrorism
- 98 - Cumulative, Not Otherwise Classified - all other
- 13 - Caught In, Under, or Between, Not Otherwise Classified
- 28 - Into Openings - shafts, excavations, floor openings, etc.
- 70 - Striking Against or Stepping On, Not Otherwise Classified
- 88 - Natural Disasters (Earthquake, Hurricane, Tornado, etc.)
- 46 - Collision with a Fixed Object - standing vehicle or stationary object
- 81 - Struck or Injured, Not Otherwise Classified -includes kicked, stabbed, bit

- 91 - Mold
- 95 - Rubbed or Abraded, Not Otherwise Classified
- 97 - Repetitive Motion - carpal tunnel syndrome
- 99 - Other - Miscellaneous, Not Otherwise Classified
- 25 - From Different Level (Elevation) - off wall, catwalk, bridge, etc.
- 45 - Collision or Sideswipe with Another Vehicle -both vehicles in motion
- 82 - Absorption, Ingestion or Inhalation, Not Otherwise Classified
- 89 - Person in Act of a Crime - robbery or criminal assault
- 20 - Collapsing Materials (Slides of Earth) - either man made or natural

Section IIA.

Block 19a1

Enter the Injured Body Area from the list below:

- | | | |
|------------|------------------------|--------------------------|
| 01 - Head | 02 - Neck | 03 - Upper Extremities |
| 04 - Trunk | 05 - Lower Extremities | 06 - Multiple Body Parts |

Block 19a2

Indicate the Injured Body Part from the list:

- | | |
|---|---|
| 10 - Multiple Head Injury | 11 - Skull |
| 12 - Brain | 13 - Ear(s) - includes: hearing, inside eardrum |
| 14 - Eye(s) - includes: optic nerves, vision, eyelids | 15 - Nose-includes: nasal passage, sinus, sense of smell |
| 16 - Teeth | 17 - Mouth - includes: lips, tongue, throat, taste |
| 18 - Soft Tissue (head) | 19 - Facial Bones - includes jaw |
| 20 - Multiple Neck Injury | 21 - Vertebrae - includes spinal column bone |
| 22 - Disc - includes spinal column cartilage | 23 - Spinal Cord (Neck) - includes: nerve tissue |
| 24 - Larynx - includes: cartilage and vocal cords | 25 - Soft Tissue (Neck) - other than larynx or trachea |
| 26 - Trachea | 30 - Multiple Upper Extremities |
| 31 - Upper Arm-Humerus and corresponding muscles | 32 - Elbow - radial head |
| 33 - Lower Arm - forearm - radius, ulna | 34 - Wrist - carpals and corresponding muscles |
| 35 - Hand - metacarpals and corresponding muscles | 36 - Finger(s) - other than thumb |
| 37 - Thumb | 38 - Shoulder(s) - Armpit, Rotator Cuff, Trapezius, Clavicle, Scapula |
| 39 - Wrist(s) and Hands(s) | 40 - Multiple Trunk |
| 41 - Upper Back Area (Thoracic Area) | 42 - Low Back Area (Lumbar Area & Lumbo-Sacral) |
| 43 - Disc-spinal column cartilage | 44 - Chest - including Ribs, Sternum and soft tissue |
| 45 - Sacrum and Coccyx - final nine vertebrae - fused | 46 - Pelvis |
| 47 - Spinal Cord (Trunk) -nerve tissue | 48 - Internal Organs - other than heart and lungs |
| 49 - Heart | 60 - Lungs |
| 61 - Abdomen Including Groin | 62 - Buttocks - soft tissue |
| 50 - Multiple Lower Extremities | 51 - Hip |
| 52 - Upper Leg - femur and corresponding muscles | 53 - Knee - patella |
| 54 - Lower Leg-tibia, fibula & corresponding muscles | 55 - Ankle - tarsals |
| 56 -Foot - metatarsals, heel, Achilles tendon | 57 - Toe(s) |
| 58 -Great Toe | 63 - Lumbar/Sacral Vertebrae (Not Otherwise Classified Trunk) |
| 64 - Artificial Appliance - braces, etc. | 65 - Insufficient Info to Properly Id-Unclassified |
| 66 -No Physical Injury - mental disorder | 90 - Multiple Body Parts |
| 91 - Body Systems & Multiple Body Systems | 99 - Whole Body Part |

Block 19a3

Indicate which side of the body that the injured body part was on.

Block 19a4

Indicate which finger or toe was injured from the list.

- | | | | |
|---------------------|-------------------|--------------------|------------------|
| 01 - Not Applicable | 02 - Index Finger | 03 - Middle Finger | 04 - Ring Finger |
| 05 - Pinky Finger | 06 - Thumb | 07 - Great Toe | 08 - 2nd Toe |
| 09 - 3rd Toe | 10 - 4th Toe | 11 - Little Toe | |

Block 19a5

Enter the Nature of Injury from the list below (list continued on next page)

- | | | |
|---|-----------------------------------|---|
| 01 - No Physical Injury | 02 - Amputation | 03 - Angina Pectoris - chest pain |
| 04 - Burn | 07 - Concussion - brain, cerebral | 10 - Contusion-bruise-intact skin surface, hematoma |
| 13 - Crushing | 16 - Dislocation | 19 - Electric Shock - electrocution |
| 22 - Eucleation - removal of organ or tumor | | 25 - Foreign Body |
| 28 - Fracture - breaking of bone or cartilage | | 30 - Freezing |



INSTRUCTIONS FOR FILING YOUR WORKER'S OR BENEFICIARY'S NOTICE OF INJURY OR
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Special Instructions for Certain Requested Information – continued

31 - Hearing Loss or Impairment		32 - Heat Prostration
34 - Hernia	36 - Infection	37 - Inflammation
40 - Laceration	41 - Myocardial Infarction	42 - Poisoning
43 - Puncture	46 - Rupture	47 - Severance
49 - Sprain	52 - Strain	53 - Syncope - swooning, fainting, passing out
54 - Asphyxiation - strangulation, drowning		55 - Vascular
58 - Vision Loss	59 - All Other Specific Injuries, Not Otherwise Classified	
60 - Dust Disease Not Otherwise Classified (All other Pneumoconiosis)		
61 - Asbestosis	62 - Black Lung	63 - Byssinosis
64 - Silicosis	65 - Respiratory Disorders (Gases, Fumes, Chemicals)	
66 - Poisoning - Chemical (Other than Metals)		67 - Poisoning - Metal - man-made
68 - Dermatitis	69 - Mental Disorder	70 - Radiation
71 - All Other Occupational Disease Injury Not Otherwise Classified		
72 - Loss of Hearing	73 - Contagious Disease	74 - Cancer
75 - AIDS	76 - VDT-Related Disease	77 - Mental Stress
78 - Carpal Tunnel Syndrome	79 - Hepatitis C	
80 - All Other Cumulative Injuries, Not Otherwise Classified		90 - Multiple Physical Injuries Only
91 - Multiple Injuries, both physical & psychological		

Note: If more than one body part is injured, use Blocks 19b1 through 19b5 and Blocks 19c1 through 19c5 as needed.

Section IIB Block 20	An occupational disease is a disease, related to your work, which causes damage to your body. This includes injuries resulting from repetitious, physically traumatic activities that happen over time and are related to your work. Examples are asbestosis (disease) and carpal tunnel syndrome (repetitive activities). In this block, give the date you knew that the disease or repetitive injury may be related to your employment.
Block 21	Give the date you last worked in the conditions that caused your disease or repetitive injury.
Section VI Block 31 - 34b	Provide information on Claim Employer. A Claim Employer is the employer that the injured worker was working for at the time of the on-the-job injury.
Section VII Block 36 - 38	Provide information on worksite where injury occurred, if different from Claim Employer location.
Section IX Block 61 – 56	Provide information on Non-Claim Employer. A Non-Claim Employer is an employer from a second job (if applicable) that was held by the injured worker at the same time of the on-the-job injury.
Section X. Block 57a - 60c	Give information on the doctor who is treating you for your injury.
Section XI Block 61 – 66e	If the answer to Question 61 is "Yes", then this section must be completed, giving information on someone that is acting on behalf of the injured worker, such as attorney, union representative, or family member. This section does not apply to a beneficiary that is completing this form as part of a Beneficiary's Claim for Compensation. A beneficiary must also complete a DWC FORM-41, Supplement A, in addition to this form.
Section XII Block 68	This section must be completed if someone other than the injured worker completed this form

