Liberty Mutual

R/OCIP @ DFW Airport Risk Management
Equipped for Success

THIS FORM MUST BE COMPLETED, IN ITS ENTIRITY, NO MORE THAN 24 HOURS AFTER THE INCIDENT OCCURS AND SUBMITTED TO THE R/OCIP CLAIMS MANAGER.
REPORT ALL WORKERS' COMPENSATION INJURIES TO CINDY GOWING (CGowing@dfwairport.com – 972-973-2391)

EMPLOYER NAME:	Subsidiary name(if applicable):
Will Employee miss time from work? Yes ☐ No ☐	
Date of Injury: **Time of Injury**:	

EMPLOYEE INFORMATION

Employee's **SSN#:**	Employee's Name:	
Date of Birth:		
Date and Time Reported to Employer:		
Did employee die: Yes ☐ No ☐	If yes, Date of Death:	**Jurisdiction of loss (State): TX**

EMPLOYER INFORMATION

Employer Location Code:			
Work Location:	City:	State:	Zip
Mailing Address (if different):	City:	State:	Zip
Nature of Business:			
Employer FEIN:	Employer Type Code:	Employer SIC.:	
Policy (Contract) Number:			

EMPLOYEE INFORMATION

Home Address:	City:	State:	Zip:
Male ☐ **Female** ☐	**Marital Status**:	**Home Phone**:	
Dependents:	No. Under 18:		
Education Level:			
Employment Status			
State Hired:	**Date of Hire**:		
Job Description:	Department Name:		
Supervisor name: Phone:	**Reported To**: Phone:		
Contact: Phone:			
Days **Weekly Hours**:	Hours Per Day	Weekly Wage:	Hourly Wage:

INJURY INFORMATION

Which Part of the Body Was Injured?	**Nature of Injury?**
Injury Description:	

MEDICAL INFORMATION

Initial Medical Treatment:	**Admitted to Hospital?** Yes ☐ No ☐ Unknown ☐
Hospital- Name Address:	Phone:
Clinic- Name Address:	Phone:

ACCIDENT INFORMATION

Nature of Accident:

Give a Full **Description of the Accident**:

Did the Accident Occur at the Work Location? YES ☐ NO ☐	If **NO,** where did the accident occur?
Accident Address: City: State: Zip:	
Are Other WC Claims Involved? YES ☐ NO ☐	
Safeguards Provided? Yes ☐ No ☐	Safeguards Utilized? Yes ☐ No ☐
Time Workday Began:	
Specific Activity at time of injury:	

WITNESS INFORMATION

Were There Any Witnesses? YES ☐ NO ☐

If Yes, List Names and How to Contact Them:

DISABILITY STATUS INFORMATION

Date Last Day Worked:	**First Full Day Out:**
Date Disability Began: **Time:**	
Date Returned to Work:	***OR*** Estimated Return to Work Date:
Light Duty Available? Yes ☐ No ☐ Unknown ☐	**Employee returned/will return on what type of duty?**
Paid for Date of Injury?	**Paid wages while disabled?** Yes ☐ No ☐ Unknown ☐

ADDITIONAL COMMENTS & INFORMATION

REPORT PREPARED BY

Name:	Title:
Signature:	Phone: