TDI Division of Workers' Compensation
PO Box 12050 | Austin, TX 78711 | 800-252-7031 | tdi.texas.gov/wc

Employer's report of non-covered employee's work-related injury or illness

If you would like to file online using your smartphone, tablet, computer, or an XML file upload, go to.
www.tdi.texas.gov/wc/forms/onlinefiling.html

Choose one:

☐ **Non-subscribing employer** (an employer that does not provide workers' compensation coverage)

☐ **Subscribing employer** (employee declined workers' compensation insurance coverage)

Part 1. Employer information

1. Business name	**2. Reporting period** (mm/yyyy)
3. Number of injured employees included in this report	**4. Business mailing address** (street or PO box, city, state, ZIP code)

5. Employer North American Industry Classification System (NAICS) codes

	Code 1	**Code 2**	**Code 3**	**Code 4**	**Code 5**
Six-digit NAICS code					
Highest number of employees in month of report*					

*Include full-time, part-time, temporary, and permanent employees.

6. Business physical address (street or PO box, city, state, ZIP code)	**7. Business employer phone number**
8. Federal employer identification number (FEIN)	**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)

Part 2. Injured employee information

14. Employee name (first, middle, last)		**15. Social Security number** (XXX-XX-XXXX)	**16. Date of birth** (mm/dd/yyyy)
17. Date of hire (mm/dd/yyyy)	**18. Sex** ☐ Male ☐ Female	**19. Occupation**	
20. Hourly wage	**21. Six-digit NAICS code of employee's work at the time of the injury or illness** Code entered must be listed in Box 5.		

22. Race and ethnic identification

☐ White ☐ Black ☐ Hispanic ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native ☐ Other (Specify if different from choices above.)

23. Address where the work-related injury or illness happened (street or PO box, city, state, ZIP code)

24. Where the injury or illness happened ☐ Primary business location ☐ On-site job location ☐ Traveling between job locations ☐ Telecommuting

25. Date of injury or illness (mm/dd/yyyy)	**26. Date reported by employee** (mm/dd/yyyy)

27. Return-to-work date (mm/dd/yyyy) ☐ **Actual date or** ☐ **Expected date**

28. Reported cause of injury (Examples: overexertion due to lifting or pushing, slip, trip, fall.)

29. Nature of injury or illness (Examples: cut, burn, bruise, fracture, sprain, strain, chemical burn, dermatitis, asbestosis, or silicosis. For more than one injury, list the most serious injury.)

30. Equipment involved in the injury, if any

31. Body parts affected

32. Number of days absent from work, not including the day of injury or the day of return to work: (continuous or intermittent)

33. First day absent from work (mm/dd/yyyy)	**34. Work-related illness?** ☐ Yes ☐ No	**35. Death?** ☐ Yes ☐ No If yes, provide date of death.

36. Describe what happened (Example: Fell off ladder and broke arm while painting house.)

Information for other injured employees

Attach more pages if needed.

Business name	Reporting period (mm/yyyy)	FEIN

14. Employee name (first, middle, last)	15. Social Security number (XXX-XX-XXXX)	16. Date of birth (mm/dd/yyyy)

17. Date of hire (mm/dd/yyyy)	18. Sex	19. Occupation
	☐ Male ☐ Female	

20. Hourly wage	21. Six-digit NAICS code of employee's work at the time of the injury or illness Code entered must be listed in Box 5.

22. Race and ethnic identification

☐ White ☐ Black ☐ Hispanic ☐ Asian or Pacific Islander ☐ American Indian or Alaskan Native

☐ Other (Specify if different from choices above.)

23. Address where the work-related injury or illness happened (street or PO box, city, state, ZIP code)

24. Where the injury or illness happened ☐ Primary business location

☐ Job-site location ☐ Traveling between job locations ☐ Telecommuting

25. Date of injury or illness (mm/dd/yyyy)	26. Date reported by employee (mm/dd/yyyy)

27. Return-to-work date (mm/dd/yyyy) ☐ **Actual date or** ☐ **Expected date**

28. Reported cause of injury (Examples: overexertion due to lifting or pushing, caught between objects, slip, trip, fall.)

29. Nature of injury or illness (Examples: cut, burn, bruise, fracture, sprain, strain, chemical burn, dermatitis, asbestosis, or silicosis. For more than one injury, list the most serious injury.)

30. Equipment involved in the injury, if any

31. Body parts affected

32. Number of days absent from work, not including the day of injury or the day of return to work: (continuous or intermittent)

33. First day absent from work (mm/dd/yyyy)	34. Work-related illness?	35. Death? ☐ Yes ☐ No
	☐ Yes ☐ No	If yes, provide date of death.

36. Describe what happened (Example: Fell off ladder and broke arm while painting house.)

FAQ

Employer's report of noncovered employee's work-related injury or illness

Who must use this form?
Employers that **do not have** workers' compensation insurance coverage (non-subscribers) and **employ five or more employees who are not exempt** from workers' compensation insurance coverage must file the DWC Form-007, *Employer's report of noncovered employee's work-related injury or illness*. Examples of exempt employees include certain domestic workers and certain farm and ranch workers.

Employers that **have** workers' compensation insurance coverage must file the DWC Form-007 to report an on-the-job injury or illness for an **employee who has waived** workers' compensation insurance coverage. See Texas Labor Code Section 406.034 for more information.

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

When do I file the DWC Form-007?
You must file the form no later than the 7th day of the month after the month:

- A work-related death happened;
- An employee was absent from work for more than one day because of an on-the-job injury; or
- The employer knew about a work-related illness.

You do not have to report months with no deaths, injuries, or illnesses.

Are any fields on the DWC Form-007 optional?
No, you must answer all fields.

Where can I find more information about NAICS codes?
Find more information at the United States Census Bureau at www.census.gov/naics.

Where do I send this form?

- Create a profile in TXCOMP and upload documents.
- **Fax:** 512-804-4146
- **Mail:** Texas Department of Insurance,
  Division of Workers' Compensation
  Business Process Operations, MC BP-OPS
  PO Box 12050
  Austin, TX 78711-2050

Questions?
Call 800-252-7031, Monday to Friday, 8 a.m. to 5 p.m., Central time. Go to www.tdi.texas.gov/wc to learn more about workers' compensation.

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 wrong information (Government Code Section 559.004).

For more info, contact DWCLegalServices@tdi.texas.gov or go to the Corrections Procedure section at www.tdi.texas.gov.