CLAIM # _____
Carrier # _____

SUPPLEMENTAL REPORT OF INJURY

Part I EMPLOYER INFORMATION

1. Employer business name	2. Employer phone #
County of Dallas	

3. Employer mailing address
509 Main Street Room 101, Dallas, Texas 75202

4. Insurance carrier name
Self-Insured

5. Does the employer have return to work (RTW) opportunities available based on the injured worker's current capabilities? yes ☐ no ☐
If so, identify contact person and phone # _____ _____

6. Has the insurance carrier provided RTW coordination services within the past 12 months? yes ☐ Date _____ no ☐

7. Has the employer requested RTW training from DWC or the insurance carrier? yes ☐ no ☐

8. Has the insurance carrier provided accident prevention services in the past 12 months? yes ☐ Date _____ no ☐

9. Has the employer requested accident prevention services from the insurance carrier? yes ☐ no ☐

Part II REASON FOR FILING THIS REPORT (deadlines vary, see instructions)

10. ☐ a. The injured worker returned to work in either a full or limited capacity: File this report within 3 days.
☐ b. The injured worker is earning more or less than the pre-injury wage because of the injury: File within 10 days.
☐ c. The injured worker returned, then later had additional lost time or reduced wages as a result of the injury: File within 3 days.
☐ d. The injured worker resigned or was terminated from employment: File within 10 days.

Part III INJURED WORKER INFORMATION

11. Injured worker name	12. SSN (last 4 digits) xxx-xx-	13. DOI
14. Injured worker mailing address and phone #		
15. First day of lost time or reduced wages for this injury (mm/dd/yyyy)	16. First day of additional lost time or reduced wages (mm/dd/yyyy)	

17, Has the injured worker experienced 8 days (cumulative) of lost time or reduced wages as a result of the injury? yes ☐ no ☐
If yes, the date of the 8th day (mm/dd/yyyy) _____

18. Date of most recent RTW _____
☐ Full duty, full pay
☐ Limited duty, full pay
☐ Limited duty, reduced pay

19. Has the injured worker resigned, been terminated or died? yes ☐ no ☐
date of resignation _____ date of termination _____ date of death _____
19a. Reason for resignation/termination _____
19b. Was the injured worker on limited duty when terminated? yes ☐ no ☐

20. Hours the injured worker was working during the pay period of _____ to _____ : _____ hours per week

Indicated hours are:
☐ Increase from pre-injury
☐ Same as pre-injury
☐ Decrease from pre-injury

21. Weekly/hourly earnings for the pay period of _____ to _____ : $ _____ weekly or $ _____

Indicated wages are:
☐ Increase from pre-injury wage
☐ Same a pre-injury wage
☐ Decrease from pre-injury wage

This form to be filed with: ***The employer's insurance carrier and the injured worker in the timeframe as noted in Part II.***

22. To the best of my knowledge the information provided in this report is accurate and may be relied upon for evaluation of eligibility for benefits.
Submitted by: ☐ Employer ☐ Injured Worker *(If no longer working for the employer where injury occurred.)*

_____ _____
Signature and Title of person completing this form Date

DWC FORM-6
Supplemental Report of Injury

DWC requires the reporting of all Return to Work and Post-Injury Change of Earnings. An injured worker is entitled to temporary income benefits if he/she has disability (defined as the inability to work, or the inability to earn wages equivalent to pre-injury wages, as a result of the injury) and has not reached maximum medical improvement (defined as having reached 104 weeks from the eighth day of lost time or when a doctor certifies that no further recovery can be reasonably anticipated). The insurance carrier shall adjust the weekly amount of temporary income benefits paid to the injured worker to match the fluctuations in weekly earnings after the injury. To ensure the insurance carrier has accurate information to calculate benefits, the DWC FORM-6 is to be completed as applicable:

By EMPLOYER	By INJURED WORKER
The **EMPLOYER** means the employer for whom the injured worker was working when the injury occurred. If the employer is the current employer, then you are responsible to provide information to the workers' compensation insurance carrier about: • The existence of earnings, and • The amount of any earnings, or • Any offers of employment. Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-21, sign and date.	If you (the **INJURED WORKER)** are no longer employed by the employer where the injury/illness occurred, then you are responsible to provide information to the workers' compensation insurance carrier about: • The existence of earnings, and • The amount of any earnings, or • Any offers of employment. This form may be used to do so. Include CLAIM and insurance carrier numbers in right upper hand corner. Complete items 1-4, 10-21, sign and date.
The EMPLOYER must file this form: • **For** a worker's injury/illness that occurs after January 1, 1991 and required the previous filing of a DWC FORM-1, Employer's First Report of Injury; and • **During** the time the injured worker is entitled to temporary income benefits (TIBs); and • **Until** the injured worker: ➢ Reaches maximum medical improvement (MMI), or ➢ Is no longer employed by the employer.	If you are employed by a new employer after the injury; and • You are receiving benefits, you must tell the insurance carrier if your wages change, regardless of whether your income went up or down; or • You are *not* receiving benefits, you must tell the insurance carrier if the injury causes you to miss work or lose income.

This report must be filed in the following situations within the timeframes indicated:

- 3 days after the injured worker begins to lose time from work as a result of the injury, if lost time did not occur immediately following the injury;
- 3 days after the injured worker returns to work;
- 3 days, when the injured worker returned to work, then later has additional day(s) of lost time as a result of the injury;
- 10 days after the end of each pay period in which the injured worker has a change in earnings as a result of the injury;
- 10 days after the injured worker resigns or is terminated.

While most of the sections on this form are self-explanatory, please note that the pay periods requested in sections 20 & 21 may be different depending on the situation for which the form is being filed:

- If the report is indicating lost time from work or the end of employment, the pay period shall be the most recent pay period prior to the lost time.
- If the report is indicating return to work or a change in earnings, the pay period shall be the pay period the injured worker is beginning.

This form is to be filed by first class mail or personal delivery with: • The insurance carrier, and • The injured worker. This report is considered filed when personally delivered or postmarked. **Failure to comply with these filing requirements, without good cause, is a Class D administrative violation, subject to a penalty not to exceed $500.**	**This form is to be filed** by first class mail or personal delivery with: • The insurance carrier. This report is considered filed when personally delivered or postmarked. **If you return to work** for the same employer or a different employer, your temporary income benefits from the insurance carrier must be adjusted. **Failure to report earned wages and/or offers of employment to the insurance carrier who is paying benefits to you is a crime that may result in fines and/or imprisonment.**

TLC§ 409.005 and Rules 120.3 and 129.4 provide the requirements regarding use of this report. The complete rule text is available on the DWC website at: http://www.tdi.texas.gov/wc/rules