

File original with employer's carrier.  
File copy with injured employee.

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| CARRIER'S CLAIM # _____<br>TWCC# _____ |
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**SUPPLEMENTAL REPORT OF INJURY**  
**DO NOT SEND THIS FORM TO TEXAS WORKER'S COMPENSATION COMMISSION UNLESS REQUESTED**

**WHEN AND WHERE TO FILE:** *For all injuries occurring January 1, 1991 or after* that require a TWCC-1, Employer's First Report of Injury, to be filed, the employer must file by first class mail or personal delivery a Supplemental Report of Injury (TWCC-6) with the employer's workers' compensation carrier and the injured employee: 1) within 3 days after the injured employee returns to work; 2) within 3 days when the employee, after returning to work, has an additional day or days of disability because of the injury; 3) within 10 days after the end of each pay period in which the employee has an increase or decrease of earnings during the time the employee is entitled to temporary income benefits; 4) within 10 days after the employee resigns or is terminated. If the employee is no longer employed by the employer, the employee is responsible for providing information to the carrier about amounts of earnings or offers of employment. The employee may use a TWCC-6, Employer's Supplemental Report of Injury for this purpose. **An employee has disability if he/she is unable to work as a result of the injury or has returned to work earning less than pre-injury wages because of the injury.**

| EMPLOYEE INFORMATION                                     |                        |                           |
|--|------------------------|---------------------------|
| 1. Employee's Name (Last, First, M.I.) and Telephone No. | 2. Social Security No. | 3. Date of Injury (m-d-y) |
| 4. Employee's Mailing Address (Street or P.O. Box)       |                        |                           |
| City   | State                  | Zip Code                  |

**TO EMPLOYER:** Based on above rule requirements, check boxes which show reasons for filing Supplemental Report of Injury this date:

|   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> employee returned to work<br>Complete Block 5a or 5b | <input type="checkbox"/> additional day(s) of disability<br>Complete Block 5b | <input type="checkbox"/> changes in weekly earnings after injury<br>Complete Blocks 5a or 5b | <input type="checkbox"/> employee terminated/resigned<br>Complete Block 5a or 5b       |
| <input type="checkbox"/> Complete Blocks 6 and 7                              | <input type="checkbox"/> Complete Block 7                                     | <input type="checkbox"/> Complete Blocks 7 and 8   | <input type="checkbox"/> Complete Block 7<br><input type="checkbox"/> Complete Block 9 |

|   |   |
|---|---|
| 5. a) If initial filing of TWCC-6, first day of disability due to injury (m-d-y)  | 5. b) If second or subsequent filing of TWCC-6, give first day of disability due to injury <u>for this period only</u> (m-d-y)  |
| 6. Date of Return to Work<br>(Check box) _____<br>Full Duty, Full Pay<br>Limited Duty: Full Pay      Reduced Pay  | 7. Weekly and Hourly Earnings at time of This Report<br>(Check box) _____ \$ _____ weekly<br>Same as Preinjury Wages      \$ _____ hourly<br>increase from Preinjury Wages      Decrease from Preinjury Wages |
| 8. No. of Hours working Weekly at time of This Report _____<br>(Check box) _____<br>Increase from Preinjury Hours Worked Weekly<br>Same as Preinjury      Decrease from Preinjury Hours worked Weekly | 9. If the employee resigns or is terminated, fill in the appropriate section.<br>Date of Resignation (m-d-y) _____<br>Date of Termination (m-d-y) _____   |
| 10. If applicable, eight days of disability began on (m-d-y) [see above definition of disability]   | 9a. Reason for Resignation or Termination   |
| 11. Has injured employee died? If so, give date of death (m-d-y)  | 12. Was employee on limited duty at time of termination?<br>Yes      No   |

| EMPLOYER INFORMATION  |  |
|---|--|
| 13. Employer's Business Name<br>University of Houston   | 14. Telephone No.<br>(713) 743-5865          |
| 15. Employer's Business Mailing Address (Street or P.O. Box)<br>4800 Calhoun  |  |
| City<br>Houston   | State      Zip Code<br>Texas      77204-1852 |
| 16. Name of Worker's Compensation Carrier for Above Injury<br>Workers' Compensation Division, State Office of Risk Management   |  |
| The information provided in this report is accurate to the best of my knowledge. It may be relied upon for evaluation of the named employee's eligibility for benefits. |  |
| Workers' Compensation Claim Coordinator   |  |
| Signature and Title of Person Completing Form   | Date   |
| Employer  | Employee                                     |