571

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

"Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, Unless the Division specifically requests a direct filing.

CLAIM #

CARRIER'S CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex F ☑ M ☐
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y) 12 - 12 - 83
6. Does the Employee Speak English? If No, Specify Language YES ☑ NO ☐
7. Race White ☑ Black ☐ Asian ☐
8. Ethnicity Hispanic ☐ Native American ☐ Other ☑
9. Mailing Address Street or P.O. Box
City State Zip Code County
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☑ Divorced ☐
11. Number of Dependent Children 0
12. Spouse's Name
13. Doctor's Name
14. Doctor's Mailing Address (Street or P.O.Box)
City State Zip Code

15. Date of Injury (m-d-y) 06 - 06 - 07
16. Time of Injury 2 :00 am ☐ pm ☑
17. Date Lost Time Began (m-d-y) NLT - -
18. Nature of Injury* cut
19. Part of Body Injured or Exposed* left index finger
20. How and Why Injury/Illness Occurred* cutting lymph node of TB positive cow
21. Was employee doing his regular job? YES ☑ NO ☐
22. Work site Location of Injury (stairs, dock, etc.)* Necropsy
23. Address Where Injury or Exposure occurred on a business site Vet. Med. Teaching Hospital
Street or P.O. Box University Drive
County Brazos
City College Station State TX Zip Code 77845
24. Cause of Injury(fall, tool, machine, etc.)* cut with a knife
25. List Witnesses Dr. John Edwards, David Cruz
26. Return to work date/or expected (m-d-y) NLT - -
27. Did employee die? YES ☐ NO ☑
28. Supervisor's Name Cheryl Chamblee
29. Date Reported (m-d-y) 06 - 06 - 07

30. Date of Hire (m-d-y) 03 - 06 - 07
31. Was employee hired or recruited in Texas? YES ☑ NO ☐
32. Length of Service in Current Position Months 3 Years
33. Length of Service in Occupation Months 3 Years
34. Employee Payroll Classification Code 7561
35. Occupation of Injured Worker Student Worker I
36. Rate of Pay at this Job $6.50 Hourly $ Weekly
37. Full Work Week is: Hours Days
38. Last Paycheck was: $253.50 for 39 Hours or Days
39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form Sherry Haddix-Business Associate III
41. Name of Business Texas A&M-Vet.Med.Teaching Hosp.
42. Business Mailing Address and Telephone Number Street or P.O. Box University Dr. Bldg. 508 Telephone (979) 845-9107
City College Station State TX Zip Code 77845
43. Business Location (if different from mailing address) Number and Street
City State Zip Code
44. Federal Tax Identification Number 74-6000-531
45. Primary North American Industry Classification System Code:(6 digit) XXXX
46. Specific NAICS Code (6 digit) XXXX
47. Texas Comptroller Taxpayer No. XXXX
48. Workers' Compensation Insurance Company TAMU-Risk Management & Safety
49. Policy Number SELF INSURED
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X Sherry Haddix - Business Assoc III Date 6-6-07

DWC FORM-1 (Rev. 10/05) Page 3

DIVISION OF WORKERS' COMPENSATION

Exposure

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex ☐ F ☒ M
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y) 9/12/73
6. Does the Employee Speak English? If No, Specify Language ☒ YES ☐ NO
7. Race ☒ White ☐ Black ☐ Asian
8. Ethnicity ☒ Hispanic ☐ Native American ☐ Other
9. Mailing Address Street or P.O. Box
City State ZIP Code County
10. Marital Status ☒ Married ☐ Widowed ☐ Separted ☐ Single ☐ Divorced
11. Number of Dependent Children 0
12. Spouse's Name
13. Doctor's Name (seen for this injury) Dr. K. Wegner
14. Doctor's Mailing Address (Street or P.O. Box) 1600 University Dr., E
City College Station State TX ZIP Code 77840

15. Date of Injury (m-d-y) 1/29/02
16. Time of Injury 10:00 ☒ am ☐ pm
17. Date Lost Time Began (m-d-y) n/a
18. Nature of Injury* Exposure
19. Part of Body Injured or Exposed* systemic
20. How and Why Injury/Illness Occurred*
Laboratory work up without prior knowledge of bacterial infection. Possible exposure to Brucellosis.
21. Was Employee doing his regular job? ☒ YES ☐ NO
22. Worksite Location of Injury (stairs, dock, etc.)* lab
23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site
Street or P.O. Box 1 Sippel Rd. County Brazos
City College Station State TX ZIP Code 77843
24. Cause of Injury (fall, tool, machine, etc.)* bacteria
25. List Witnesses Dr. Melissa Libal, Melissa Pectal
26. Return to work: ☐ Date ☐ Expected
27. Did Employee die? ☐ YES ☒ NO
28. Supervisor's Name Dr. Libal
29. Date Reported (m-d-y) 1/29/02

30. Date of Hire (m-d-y) 12/28/95
31. Was employee hired or recruited in Texas? ☒ YES ☐ NO
32. Length of Service in Current Position Months 5 Years 3
33. Length of Service in Occupation Months 5 Years 3
34. Employee Payroll Classification Code/Title Code 5005
35. Occupation of Injured Worker Technician I
36. Rate of Pay at this Job $ 10.74 Hourly $ 429.60 Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $ 859.20 for 80 Hours or _____ Days
39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form Mary R. Smith, Employee Relations Representative
41. Name of Business TVMDL
42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone (409) 862-1720
City College Station State TX ZIP Code 77843-1255
43. Business location (if different from mailing address)
Number and Street MS 4471
City College Station State TX ZIP Code 77843-471
44. Federal Tax Identification Number ☒ N/A
45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A
46. Specific SIC Code * (4 digit) ☒ N/A
47. Texas Comptroller Taxpayer No. ☒ N/A
48. Workers' Compensation Insurance Company The Texas A&M University System
49. Policy Number Self-Insured
50. Did you request accident prevention services in past 12 months? ☒ N/A ☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Authorized Signature of Supervisor 2/14/2002

TWCC-1 (2-91)
2/13/91

Rule 120.2

TEXAS A&M UNIVERSITY
First Report of Injury

State law requires that you be informed that you are entitled to: (1) request to be informed about the information collected about yourself on this form (with a few exceptions as provided by law); (2) receive and review that information; and (3) have the information corrected at no charge. Contact: hradminfb@tamu.edu or (979) 845-4141.

If **student or visitor**, fax to the Environmental Health & Safety Department at 845-1348 within 24 hours of the injury/illness.
If **employee**, fax to the **Human Resources Department at 847-8546** within 24 hours of the injury/illness.

[1] Employee ☐ - *Complete items #1 - #32*
Student ☑ - *Complete items #1 - #13 & #32*
Visitor ☐ - *Complete items #1 - #13 & #32*

[2] Date of injury/illness (M-D-Y): 10/18/04

[3] Time of injury/illness: 9:15 ☒ AM ☐ PM

[4] Name (Last, First, M.I.):

[5] SSN:

[6] Address: Home: #( ) N/A Work: #( ) 979-845-4185

[7] Will medical attention be required for this injury/illness? Yes ☑ No ☐

[8] Address or location where injury or exposure occurred:
Bldg # or Street: City: CS State: TX Zip: 77843 County: BRAZOS

[9] Specific location where injury or exposure occurred *(e.g., stairs, dock, laboratory)*: laboratory

[10] Nature of injury/illness: *(e.g., bruise, cut, sprain, occupational disease)*: Possible inhilation of aersolized Brucella melitensis

[11] Body part involved *(e.g., left arm, right eye)*:

[12] Cause of injury/illness *(e.g., fall, tool, machine, chemical)*: lab accident

[13] How and why did this injury/illness occur?
Cap of a flask containing Brucella melitensis came off, possibly aerosilizing Brucella melitensis.

[14] Date Hired: / / [15] Job Title: [16] Full Time ☐ Part Time ☐

[17] Spouse's Name: [18] Number of dependent children:

[19] Does employee speak English? Yes ☐ No ☐
If No, specify language:

[20] Date lost time began, *more than one full shift (M-D-Y)*: / /

[21] Length of service in *current* position: Months Years [22] Dept:

[23] Doctor's name: Doctor's address:

[24] Will employee miss more than shift? Yes ☐ No ☐

[25] Was employee doing his/her job? Yes ☐ No [26] Did employee die as a result of this illness/injury? Yes ☐ No ☐

[27] Was the employee using a back belt at the time of the injury? Yes ☐ No ☐

[28] List of witnesses:

[29] Supervisor's Name & telephone #: [30] Date injury/illness was reported: / / [31] Expected or return to work date: / /

[32] **Authorized Representative/Supervisor's** signature and title: (not injured employee)
X _____ Title: GAR Date: 10/18/04
I confirm that the information furnished is true and complete to the best of my knowledge.

Exposure

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex: ☒ F ☐ M
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y): 5/28/76
6. Does the Employee Speak English? If No, Specify Language: ☒ YES ☐ NO
7. Race: ☒ White ☐ Black ☐ Asian
8. Ethnicity: ☐ Hispanic ☐ Native American ☐ Other
9. Mailing Address
Street or P.O. Box
City | State | ZIP Code | County
10. Marital Status: ☐ Married ☐ Widowed ☐ Separted ☒ Single ☐ Divorced
11. Number of Dependent Children: 0
12. Spouse's Name: n/a
13. Doctor's Name (seen for this injury): Dr. Gaines
14. Doctor's Mailing Address (Street or P.O. Box): 1600 University Dr. E
City: College Station | State: TX | ZIP Code: 77840

15. Date of Injury (m-d-y): 1/28/02
16. Time of Injury: 9:30 ☒ am ☐ pm
17. Date Lost Time Began (m-d-y): n/a
18. Nature of Injury*: Exposure
19. Part of Body Injured or Exposed*: Respiratory System
20. How and Why Injury/Illness Occurred*: Employee was working with culture plates from an animal that i was not aware has Burcellosis/or had been vaccinated.
21. Was Employee doing his regular job? ☒ YES ☐ NO
22. Worksite Location of Injury (stairs, dock, etc.)*: lab
23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site
Street or P.O. Box: 1 Sippel Rd. | County: Brazos
City: College Station | State: TX | ZIP Code: 77843
24. Cause of Injury (fall, tool, machine, etc.)*: Brucella bactus
25. List Witnesses: Jorge Medona
26. Return to work: ☐ Date ☐ Expected
27. Did Employee die? ☐ YES ☒ NO
28. Supervisor's Name: Dr. Melissa Libal
29. Date Reported (m-d-y): 1/29/02

30. Date of Hire (m-d-y): 2/04/99
31. Was employee hired or recruited in Texas? ☒ YES ☐ NO
32. Length of Service in Current Position: Months 6 Years 2
33. Length of Service in Occupation: Months 6 Years 2
34. Employee Payroll Classification Code/Title Code: 5005
35. Occupation of Injured Worker: Technician
36. Rate of Pay at this Job: $ 10.45 Hourly $ 418.00 Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $ 836.00 for 80 Hours or _____ Days
39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form: Mary R. Smith, Employee Relations Representative
41. Name of Business: TVMDL
42. Business Mailing Address and Telephone Number
Street or PO Box: MS 1255 Telephone: (409) 862-1720
City: College Station | State: TX | ZIP Code: 77843-1255
43. Business location (if different from mailing address)
Number and Street: MS 4471
City: College Station | State: TX | ZIP Code: 77843-4471
44. Federal Tax Identification Number: ☒ N/A
45. Primary Standard Industrial Classification SIC Code * (4 digit): ☒ N/A
46. Specific SIC Code * (4 digit): ☒ N/A
47. Texas Comptroller Taxpayer No.: ☒ N/A
48. Workers' Compensation Insurance Company: The Texas A&M University System
49. Policy Number: Self-Insured
50. Did you request accident prevention services in past 12 months? ☒ N/A ☐ YES ☐ NO
If yes, did you receive them? ☐ YES ☐ NO
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Authorized Signature of Supervisor
2/13/2002

TWCC-1 (2-91)
2/13/91

Rule 120.2

390

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

"Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, Unless the Division specifically requests a direct filing.

CLAIM #

CARRIER'S CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☑ M ☐

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 12 - 20 - 1956

6. Does the Employee Speak English? YES ☑ NO ☐ If No, Specify Language

7. Race White ☑ Black ☐ Asian ☐

8. Ethnicity Hispanic ☐ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status Married ☑ Widowed ☐ Separated ☐ Single ☐ Divorced ☐

11. Number of Dependent Children: 0

12. Spouse's Name

13. Doctor's Name: Dr. Russell Biles

14. Doctor's Mailing Address (Street or P.O.Box): Scott and White

City: College Station State: TX Zip Code

15. Date of Injury (m-d-y): 05 - 10 - 07

16. Time of Injury: 2 :30 am ☐ pm ☑

17. Date Lost Time Began (m-d-y): N/A

18. Nature of Injury*: Puncture

19. Part of Body Injured or Exposed*: Left Index Finger

20. How and Why Injury/Illness Occurred*: Recapping needle - Did not realize needle had gone thru the cap. Needle possible infected w/bacteria or PDD virus.

21. Was employee doing his regular job? YES ☑ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)*: Lab

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site: Veterinary Pathobiology

Street or P.O. Box: TAMU County: Brazos

City: College Station State: Zip Code

24. Cause of Injury(fall, tool, machine, etc.)*: Needle

25. List Witnesses: None

26. Return to work date/or expected (m-d-y):

27. Did employee die? YES ☐ NO ☑

28. Supervisor's Name: Dr. Susan Payne

29. Date Reported (m-d-y): 05 .11 .07

30. Date of Hire (m-d-y): 02 - 14 - 00

31. Was employee hired or recruited in Texas? YES ☑ NO ☐

32. Length of Service in Current Position: Months 9 Years

33. Length of Service in Occupation: Months Years 7

34. Employee Payroll Classification Code: 9247

35. Occupation of Injured Worker: Reseach Assistant

36. Rate of Pay at this Job: $13.07 Hourly $ Weekly

37. Full Work Week is: 40 Hours Days

38. Last Paycheck was: $2395 for Hours or 21 Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form: Jeanine Malazzo, Business Coordinator I

41. Name of Business: Texas A&M University System

42. Business Mailing Address and Telephone Number
Street or P.O. Box: 4467 TAMU Telephone: (979) 845-5944

City: College Station State: TX Zip Code: 77843

43. Business Location (If different from mailing address)
Number and Street

City State Zip Code

44. Federal Tax Identification Number

45. Primary North American Industry Classification System Code:(6 digit)

46. Specific NAICS Code (6 digit)

47. Texas Comptroller Taxpayer No.

48. Workers' Compensation Insurance Company

49. Policy Number

50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)

X Jeanine Malazzo Date 5-11-07

DIVISION OF WORKERS' COMPENSATION

Tx 90 Tx 90

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex ☒ F ☐ M
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y) 8/29/53
6. Does the Employee Speak English? If No, Specify Language ☒ YES ☐ NO
7. Race ☒ White ☐ Black ☐ Asian
8. Ethnicity ☒ Hispanic ☐ Native American ☐ Other
9. Mailing Address Street or P.O. Box
City State ZIP Code County
10. Marital Status ☐ Married ☐ Widowed ☐ Separted ☒ Single ☐ Divorced
11. Number of Dependent Children 0
12. Spouse's Name n/a
13. Doctor's Name (seen for this injury) Dr. Thomas Ginn
14. Doctor's Mailing Address (Street or P.O. Box) 3201 University Dr., E.
City College Station State TX ZIP Code 77840

15. Date of Injury (m-d-y) 1/21/02
16. Time of Injury 10:00 ☒ am ☐ pm
17. Date Lost Time Began (m-d-y) n/a
18. Nature of Injury* Exposure
19. Part of Body Injured or Exposed* Whole body
20. How and Why Injury/Illness Occurred* Possible exposure to Leptospirosis, while setting up unrine culture and not aware of animal's condition.
21. Was Employee doing his regular job? ☒ YES ☐ NO
22. Worksite Location of Injury (stairs, dock, etc.)* Lab
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site Bldg. 1085
Street or P.O. Box County Brazos
City College Station State TX ZIP Code 77843
24. Cause of Injury (fall, tool, machine, etc.)* infected urine
25. List Witnesses none
26. Return to work: ☐ Date ☐ Expected
27. Did Employee die? ☐ YES ☒ NO
28. Supervisor's Name Kim Dubose
29. Date Reported (m-d-y) 1/18/02

30. Date of Hire (m-d-y) 9/09/82
31. Was employee hired or recruited in Texas? ☒ YES ☐ NO
32. Length of Service in Current Position Months 4 Years 19
33. Length of Service in Occupation Months 4 Years 19
34. Employee Payroll Classification Code/Title Code 5005
35. Occupation of Injured Worker Vet Tech I
36. Rate of Pay at this Job $ 12.57 Hourly $ 502.80 Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $ 1005.60 for 80 Hours or ____ Days
39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form Mary R. Smith SR HR Technician
41. Name of Business VSAM
42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone (409) 862-1720
City College Station State TX ZIP Code 77843-1255
43. Business location (if different from mailing address)
Number and Street MS 4457
City College Station State TX ZIP Code 77843-4457
44. Federal Tax Identification Number ☒ N/A
45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A
46. Specific SIC Code * (4 digit) ☒ N/A
47. Texas Comptroller Taxpayer No. ☒ N/A
48. Workers' Compensation Insurance Company The Texas A&M University System
49. Policy Number Self-Insured
50. Did you request accident prevention services in past 12 months? ☒ N/A ☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 1/22/2002
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

Tx exposure to leptospir
Tx whole body

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex ☒ F ☐ M
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y) 11/07/82
6. Does the Employee Speak English? If No, Specify Language ☒ YES ☐ NO
7. Race ☒ White ☐ Black ☐ Asian
8. Ethnicity ☐ Hispanic ☐ Other ☐ Native American
9. Mailing Address Street or P.O. Box
City State ZIP Code County
10. Marital Status ☐ Married ☐ Widowed ☐ Separted ☒ Single ☐ Divorced
11. Number of Dependent Children 0
12. Spouse's Name n/a
13. Doctor's Name (seen for this injury)
14. Doctor's Mailing Address (Street or P.O. Box)
City State ZIP Code

15. Date of Injury (m-d-y) 1/15/02
16. Time of Injury 10:00 ☒ am ☐ pm
17. Date Lost Time Began (m-d-y) n/a
18. Nature of Injury* Exposure/Positive
19. Part of Body Injured or Exposed* body
20. How and Why Injury/Illness Occurred*
Handling infected patient, urine, bedding from patient postive for Leptospirosis. Employee has now tested positive.
21. Was Employee doing his regular job? ☒ YES ☐ NO
22. Worksite Location of Injury (stairs, dock, etc.)* Small animal ICU
23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site Vet Hosp
Street or P.O. Box County Brazos
City College Station State TX ZIP Code 77843
24. Cause of Injury (fall, tool, machine, etc.)* dog
25. List Witnesses
26. Return to work: ☐ Date ☐ Expected
27. Did Employee die? ☐ YES ☒ NO
28. Supervisor's Name Jessica Brier
29. Date Reported (m-d-y) 1/17/02

30. Date of Hire (m-d-y) 8/27/01
31. Was employee hired or recruited in Texas? ☒ YES ☐ NO
32. Length of Service in Current Position Months 5 Years 0
33. Length of Service in Occupation Months 5 Years 0
34. Employee Payroll Classification Code/Title Code 7565
35. Occupation of Injured Worker Student Tech
36. Rate of Pay at this Job $ 9.49 Hourly $ 189.80 Weekly
37. Full Work Week is: 20 Hours _____ Days
38. Last Paycheck was: $ 199.29 for 21 Hours or _____ Days
39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form Mary R. Smith SR HR Technician
41. Name of Business VTEA
42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone (409) 862-1720
City College Station State TX ZIP Code 77843-1255
43. Business location (if different from mailing address)
Number and Street MS 4457
City College Station State TX ZIP Code 77843-4457
44. Federal Tax Identification Number ☒ N/A
45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A
46. Specific SIC Code * (4 digit) ☒ N/A
47. Texas Comptroller Taxpayer No. ☒ N/A
48. Workers' Compensation Insurance Company The Texas A&M University System
49. Policy Number Self-Insured
50. Did you request accident prevention services in past 12 months? ☒ N/A ☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 1/24/2002
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex ☐ F ☐ M

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 11/17/75

6. Does the Employee Speak English? If No, Specify Language ☒ YES ☐ NO

7. Race ☒ White ☐ Black ☐ Asian

8. Ethnicity ☐ Hispanic ☐ Other ☐ Native American

9. Mailing Address
Street or P.O. Box

City State ZIP Code County

10. Marital Status ☐ Married ☐ Widowed ☐ Separted ☒ Single ☐ Divorced

11. Number of Dependent Children 0

12. Spouse's Name n/a

13. Doctor's Name (seen for this injury)

14. Doctor's Mailing Address (Street or P.O. Box)

City State ZIP Code

15. Date of Injury (m-d-y) 1/16/02

16. Time of Injury 10:00 ☒ am ☐ pm

17. Date Lost Time Began (m-d-y) n/a

18. Nature of Injury* Exposure

19. Part of Body Injured or Exposed* body

20. How and Why Injury/Illness Occurred*
Handling infected patient, urine and bedding of patient positive for Leptospirosis.

21. Was Employee doing his regular job? ☒ YES ☐ NO

22. Worksite Location of Injury (stairs, dock, etc.)* Small animal ICU

23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site Vet Hosp
Street or P.O. Box
County Brazos
City College Station State TX ZIP Code 77843

24. Cause of Injury (fall, tool, machine, etc.)* dog

25. List Witnesses none

26. Return to work: ☐ Date ☐ Expected

27. Did Employee die? ☐ YES ☒ NO

28. Supervisor's Name Jessica Brier

29. Date Reported (m-d-y) 1/17/02

30. Date of Hire (m-d-y) 10/09/01

31. Was employee hired or recruited in Texas? ☒ YES ☐ NO

32. Length of Service in Current Position Months 4 Years 0

33. Length of Service in Occupation Months 4 Years 0

34. Employee Payroll Classification Code/Title Code 5065

35. Occupation of Injured Worker Vet Tech I

36. Rate of Pay at this Job $ 11.98 Hourly $ 479.20 Weekly

37. Full Work Week is: 40 Hours 5 Days

38. Last Paycheck was: $ 1102.16 for 92 Hours or ____ Days

39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form
Mary R. Smith SR HR Technician

41. Name of Business
VTEA

42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone (409) 862-1720
City College Station State TX ZIP Code 77843-1255

43. Business location (if different from mailing address)
Number and Street MS 4457
City College Station State TX ZIP Code 77843-4457

44. Federal Tax Identification Number ☒ N/A

45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A

46. Specific SIC Code * (4 digit) ☒ N/A

47. Texas Comptroller Taxpayer No. ☒ N/A

48. Workers' Compensation Insurance Company
The Texas A&M University System

49. Policy Number
Self-Insured

50. Did you request accident prevention services in past 12 months? ☒ N/A
☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 1/24/2002
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex ☒ F ☐ M
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y) 11/16/70
6. Does the Employee Speak English? If No, Specify Language ☒ YES ☐ NO
7. Race ☒ White ☐ Black ☐ Asian
8. Ethnicity ☐ Hispanic ☐ Native American ☐ Other
9. Mailing Address Street or P.O. Box
City State ZIP Code County
10. Marital Status ☐ Married ☐ Widowed ☐ Separted ☒ Single ☐ Divorced
11. Number of Dependent Children 0
12. Spouse's Name n/a
13. Doctor's Name (seen for this injury)
14. Doctor's Mailing Address (Street or P.O. Box)
City State ZIP Code

15. Date of Injury (m-d-y) 1/12/02
16. Time of Injury 10:00 ☒ am ☐ pm
17. Date Lost Time Began (m-d-y) n/a
18. Nature of Injury* Exposure
19. Part of Body Injured or Exposed* Body
20. How and Why Injury/Illness Occurred* Handling infected patient, urine and bedding from patient positive for Leptospirosis.
21. Was Employee doing his regular job? ☒ YES ☐ NO
22. Worksite Location of Injury (stairs, dock, etc.)* Small animal ICU
23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site Vet Hosp
Street or P.O. Box County Brazos
City College Station State TX ZIP Code 77843
24. Cause of Injury (fall, tool, machine, etc.)* dog
25. List Witnesses
26. Return to work: ☐ Date ☐ Expected
27. Did Employee die? ☐ YES ☒ NO
28. Supervisor's Name Jessica Brier
29. Date Reported (m-d-y) 1/17/02

30. Date of Hire (m-d-y) 6/27/00
31. Was employee hired or recruited in Texas? ☒ YES ☐ NO
32. Length of Service in Current Position Months 1 Years 8
33. Length of Service in Occupation Months 1 Years 8
34. Employee Payroll Classification Code/Title Code 5065
35. Occupation of Injured Worker Vet Tech I
36. Rate of Pay at this Job $ 11.98 Hourly $ 479.20 Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $ 1250.95 for 104.4 Hours or _____ Days
39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form Mary R. Smith SR HR Technician
41. Name of Business VTEA
42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone (409) 862-1720
City College Station State TX ZIP Code 77843-1255
43. Business location (if different from mailing address)
Number and Street MS 4457
City College Station State TX ZIP Code 77843-4457
44. Federal Tax Identification Number ☒ N/A
45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A
46. Specific SIC Code * (4 digit) ☒ N/A
47. Texas Comptroller Taxpayer No. ☒ N/A
48. Workers' Compensation Insurance Company The Texas A&M University System
49. Policy Number Self-Insured
50. Did you request accident prevention services in past 12 months? ☒ N/A ☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 1/24/2002
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex ☒ F ☐ M

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 4/23/75

6. Does the Employee Speak English? If No, Specify Language ☒ YES ☐ NO

7. Race ☒ White ☐ Black ☐ Asian

8. Ethnicity ☐ Hispanic ☐ Native American ☐ Other

9. Mailing Address
Street or P.O. Box

City State ZIP Code County

10. Marital Status ☐ Married ☐ Widowed ☐ Separted ☒ Single ☐ Divorced

11. Number of Dependent Children 0

12. Spouse's Name n/a

13. Doctor's Name (seen for this injury)

14. Doctor's Mailing Address (Street or P.O. Box)

City State ZIP Code

15. Date of Injury (m-d-y) 1/17/02

16. Time of Injury 10:00 ☒ am ☐ pm

17. Date Lost Time Began (m-d-y) n/a

18. Nature of Injury* Exposure

19. Part of Body Injured or Exposed* body

20. How and Why Injury/Illness Occurred*
Handling infected patient, urine and bedding from patient positive for Leptospirosis.

21. Was Employee doing his regular job? ☒ YES ☐ NO

22. Worksite Location of Injury (stairs, dock, etc.)* Small animal ICU

23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site Vet Hosp
Street or P.O. Box County Brazos
City College Station State TX ZIP Code 77843

24. Cause of Injury (fall, tool, machine, etc.)* dog

25. List Witnesses none

26. Return to work: ☐ Date ☐ Expected

27. Did Employee die? ☐ YES ☒ NO

28. Supervisor's Name Jessica Brier

29. Date Reported (m-d-y) 1/17/02

30. Date of Hire (m-d-y) 9/01/01

31. Was employee hired or recruited in Texas? ☒ YES ☐ NO

32. Length of Service in Current Position Months 5 Years 0

33. Length of Service in Occupation Months 5 Years 0

34. Employee Payroll Classification Code/Title Code 5066

35. Occupation of Injured Worker Vet Tech

36. Rate of Pay at this Job $ 13.69 Hourly $ 547.60 Weekly

37. Full Work Week is: 40 Hours 5 Days

38. Last Paycheck was: $ 1095.20 for 80 Hours or ____ Days

39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form
Mary R. Smith SR HR Technician

41. Name of Business
VTEA

42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone (409) 862-1720
City College Station State TX ZIP Code 77843-1255

43. Business location (if different from mailing address)
Number and Street MS 4457
City College Station State TX ZIP Code 77843-4457

44. Federal Tax Identification Number ☒ N/A

45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A

46. Specific SIC Code * (4 digit) ☒ N/A

47. Texas Comptroller Taxpayer No. ☒ N/A

48. Workers' Compensation Insurance Company
The Texas A&M University System

49. Policy Number
Self-Insured

50. Did you request accident prevention services in past 12 months? ☒ N/A ☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 1/24/2002
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex ☒ F ☐ M

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 4/27/76

6. Does the Employee Speak English? If No, Specify Language ☒ YES ☐ NO

7. Race ☒ White ☐ Black ☐ Asian

8. Ethnicity ☐ Hispanic ☐ Other ☐ Native American

9. Mailing Address
Street or P.O. Box

City State ZIP Code County

10. Marital Status ☒ Married ☐ Widowed ☐ Separted ☐ Single ☐ Divorced

11. Number of Dependent Children 0

12. Spouse's Name n/a

13. Doctor's Name (seen for this injury)

14. Doctor's Mailing Address (Street or P.O. Box)

City State ZIP Code

15. Date of Injury (m-d-y) 1/17/02

16. Time of Injury 10:00 ☒ am ☐ pm

17. Date Lost Time Began (m-d-y) n/a

18. Nature of Injury* Exposure

19. Part of Body Injured or Exposed* body

20. How and Why Injury/Illness Occurred*
Handling infected patient, urine and bedding in patient cage. Patient posititve for Leptospirosis.

21. Was Employee doing his regular job? ☒ YES ☐ NO

22. Worksite Location of Injury (stairs, dock, etc.)* Small animal ICU

23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site Vet Hosp
Street or P.O. Box County Brazos
City College Station State TX ZIP Code 77843

24. Cause of Injury (fall, tool, machine, etc.)* dog

25. List Witnesses none

26. Return to work: ☐ Date ☐ Expected

27. Did Employee die? ☐ YES ☒ NO

28. Supervisor's Name Jessica Brier

29. Date Reported (m-d-y) 1/17/02

30. Date of Hire (m-d-y) 7/10/01

31. Was employee hired or recruited in Texas? ☒ YES ☐ NO

32. Length of Service in Current Position Months 6 Years 0

33. Length of Service in Occupation Months 6 Years 0

34. Employee Payroll Classification Code/Title Code 5065

35. Occupation of Injured Worker Vet Tech I

36. Rate of Pay at this Job $ 11.98 Hourly $ 80 Weekly

37. Full Work Week is: 40 Hours 5 Days

38. Last Paycheck was: $ 958.40 for 80 Hours or _____ Days

39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form
Mary R. Smith SR HR Technician

41. Name of Business
VTEA

42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone (409) 862-1720
City College Station State TX ZIP Code 77843-1255

43. Business location (if different from mailing address)
Number and Street MS 4457
City College Station State TX ZIP Code 77843-4457

44. Federal Tax Identification Number ☒ N/A

45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A

46. Specific SIC Code * (4 digit) ☒ N/A

47. Texas Comptroller Taxpayer No. ☒ N/A

48. Workers' Compensation Insurance Company
The Texas A&M University System

49. Policy Number
Self-Insured

50. Did you request accident prevention services in past 12 months? ☒ N/A
☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 1/24/2002
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex ☒ F ☐ M

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 10/31/78

6. Does the Employee Speak English? If No, Specify Language ☒ YES ☐ NO

7. Race ☒ White ☐ Black ☐ Asian

8. Ethnicity ☐ Hispanic ☐ Native American ☐ Other

9. Mailing Address Street or P.O. Box

City State ZIP Code County

10. Marital Status ☐ Married ☐ Widowed ☐ Separted ☒ Single ☐ Divorced

11. Number of Dependent Children 0

12. Spouse's Name n/a

13. Doctor's Name (seen for this injury)

14. Doctor's Mailing Address (Street or P.O. Box)

City State ZIP Code

15. Date of Injury (m-d-y) 1/18/02

16. Time of Injury 11:00 ☒ am ☐ pm

17. Date Lost Time Began (m-d-y) n/a

18. Nature of Injury* Exposure

19. Part of Body Injured or Exposed* body

20. How and Why Injury/Illness Occurred*
Handling infected patient, urine, and bedding in patient cage. Patient positive for Leptospirosis.

21. Was Employee doing his regular job? ☒ YES ☐ NO

22. Worksite Location of Injury (stairs, dock, etc.)* Small animal ICU

23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site Vet Hospital
Street or P.O. Box County Brazos
City College Station State TX ZIP Code 77843

24. Cause of Injury (fall, tool, machine, etc.)* dog

25. List Witnesses

26. Return to work: ☐ Date ☐ Expected

27. Did Employee die? ☐ YES ☒ NO

28. Supervisor's Name Jessica Brier

29. Date Reported (m-d-y) 1/18/02

30. Date of Hire (m-d-y) 1/11/01

31. Was employee hired or recruited in Texas? ☒ YES ☐ NO

32. Length of Service in Current Position Months 0 Years 1

33. Length of Service in Occupation Months 0 Years 1

34. Employee Payroll Classification Code/Title Code 7561

35. Occupation of Injured Worker Vet Tech I

36. Rate of Pay at this Job $ 7.25 Hourly $ 108.75 Weekly

37. Full Work Week is: 15 Hours _____ Days

38. Last Paycheck was: $ 174.00 for 24 Hours or _____ Days

39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form
Mary R. Smith SR HR Technician

41. Name of Business
VTEA

42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone (409) 862-1720
City College Station State TX ZIP Code 77843-1255

43. Business location (if different from mailing address)
Number and Street MS 4457
City College Station State TX ZIP Code 77843-4457

44. Federal Tax Identification Number ☒ N/A

45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A

46. Specific SIC Code * (4 digit) ☒ N/A

47. Texas Comptroller Taxpayer No. ☒ N/A

48. Workers' Compensation Insurance Company
The Texas A&M University System

49. Policy Number
Self-Insured

50. Did you request accident prevention services in past 12 months? ☒ N/A
☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 1/24/2002
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.): A
2. Sex: ☒ F ☐ M
3. Social Security Number: 599-16-2129
4. Home Phone: 979/691-2315
5. Date of Birth (m-d-y): 6/12/73
6. Does the Employee Speak English? ☒ YES ☐ NO If No, Specify Language:
7. Race: ☒ White ☐ Black ☐ Asian
8. Ethnicity: ☐ Hispanic ☐ Other ☐ Native American
9. Mailing Address Street or P.O. Box:
City: State: ZIP Code: County:
10. Marital Status: ☒ Married ☐ Widowed ☐ Separted ☐ Single ☐ Divorced
11. Number of Dependent Children: 0
12. Spouse's Name: Chris Day
13. Doctor's Name (seen for this injury):
14. Doctor's Mailing Address (Street or P.O. Box):
City: State: ZIP Code:

15. Date of Injury (m-d-y): 1/14/02
16. Time of Injury: 10:00 ☒ am ☐ pm
17. Date Lost Time Began (m-d-y): n/a
18. Nature of Injury*: Exposure
19. Part of Body Injured or Exposed*: body
20. How and Why Injury/Illness Occurred*: Handling infected patient, urine and bedding. Patient positive for Leptospirosis.
21. Was Employee doing his regular job? ☒ YES ☐ NO
22. Worksite Location of Injury (stairs, dock, etc.)*: Small animal ICU
23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site: Vet Hosp
Street or P.O. Box: County: Brazos
City: College Station State: TX ZIP Code: 77843
24. Cause of Injury (fall, tool, machine, etc.)*: dog
25. List Witnesses:
26. Return to work: ☐ Date ☐ Expected
27. Did Employee die? ☐ YES ☒ NO
28. Supervisor's Name: Jessica Brier
29. Date Reported (m-d-y): 1/17/02

30. Date of Hire (m-d-y): 5/21/01
31. Was employee hired or recruited in Texas? ☒ YES ☐ NO
32. Length of Service in Current Position: Months 6 Years 0
33. Length of Service in Occupation: Months 9 Years 0
34. Employee Payroll Classification Code/Title Code: 5065
35. Occupation of Injured Worker: Vet Tech I
36. Rate of Pay at this Job: $ 11.98 Hourly $ 603.96 Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $ 1219.92 for 101.8 Hours or ____ Days
39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form: Mary R. Smith SR Technician
41. Name of Business: VTEA
42. Business Mailing Address and Telephone Number
Street or PO Box: MS 1255 Telephone: (409) 862-1720
City: College Station State: TX ZIP Code: 77843-1255
43. Business location (if different from mailing address)
Number and Street: MS 4457
City: College Station State: TX ZIP Code: 77843-4457
44. Federal Tax Identification Number: ☒ N/A
45. Primary Standard Industrial Classification SIC Code * (4 digit): ☒ N/A
46. Specific SIC Code * (4 digit): ☒ N/A
47. Texas Comptroller Taxpayer No.: ☒ N/A
48. Workers' Compensation Insurance Company: The Texas A&M University System
49. Policy Number: Self-Insured
50. Did you request accident prevention services in past 12 months? ☒ N/A ☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Authorized Signature of Supervisor
1/24/2002

TWCC-1 (2-91)
2/13/91

Rule 120.2

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex ☒ F ☐ M

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 3/30/78

6. Does the Employee Speak English? If No, Specify Language ☐ YES ☐ NO

7. Race ☒ White ☐ Black ☐ Asian

8. Ethnicity ☐ Hispanic ☐ Other ☐ Native American

9. Mailing Address
Street or P.O. Box

City State ZIP Code County

10. Marital Status ☐ Married ☐ Widowed ☐ Separted ☒ Single ☐ Divorced

11. Number of Dependent Children 0

12. Spouse's Name n/a

13. Doctor's Name (seen for this injury)

14. Doctor's Mailing Address (Street or P.O. Box)

City State ZIP Code

15. Date of Injury (m-d-y) 1/10/02

16. Time of Injury 8:00 ☒ am ☐ pm

17. Date Lost Time Began (m-d-y) n/a

18. Nature of Injury* Exposure

19. Part of Body Injured or Exposed* body

20. How and Why Injury/Illness Occurred*
Handling infected patient, urine and bedding from patient infected with Leptospirosis.

21. Was Employee doing his regular job? ☒ YES ☐ NO

22. Worksite Location of Injury (stairs, dock, etc.)* Small animal ICU

23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site Vet Hosp
Street or P.O. Box County Brazos
City College Station State TX ZIP Code 77843

24. Cause of Injury (fall, tool, machine, etc.)* dog

25. List Witnesses Amanda Garner

26. Return to work: ☐ Date ☐ Expected

27. Did Employee die? ☐ YES ☒ NO

28. Supervisor's Name Theresa Bramson

29. Date Reported (m-d-y) 1/17/02

30. Date of Hire (m-d-y) 5/22/00

31. Was employee hired or recruited in Texas? ☒ YES ☐ NO

32. Length of Service in Current Position Months 9 Years 1

33. Length of Service in Occupation Months 9 Years 1

34. Employee Payroll Classification Code/Title Code

35. Occupation of Injured Worker

36. Rate of Pay at this Job $ 16.57 Hourly $ 662.80 Weekly

37. Full Work Week is: 40 Hours 5 Days

38. Last Paycheck was: $ 1875.23 for 80 Hours or _____ Days

39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form
Mary R. Smith SR HR Technician

41. Name of Business
VTEA

42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone (409) 862-1720
City College Station State TX ZIP Code 77843-1255

43. Business location (if different from mailing address)
Number and Street MS 4457
City College Station State TX ZIP Code 77843-4457

44. Federal Tax Identification Number ☒ N/A

45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A

46. Specific SIC Code * (4 digit) ☒ N/A

47. Texas Comptroller Taxpayer No. ☒ N/A

48. Workers' Compensation Insurance Company
The Texas A&M University System

49. Policy Number
Self-Insured

50. Did you request accident prevention services in past 12 months? ☒ N/A
☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 1/24/2002
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex ☒ F ☐ M
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y) 5/16/78
6. Does the Employee Speak English? If No, Specify Language ☒ YES ☐ NO
7. Race ☒ White ☐ Black ☐ Asian
8. Ethnicity ☐ Hispanic ☐ Native American ☐ Other
9. Mailing Address Street or P.O. Box
City State ZIP Code County
10. Marital Status ☐ Married ☐ Widowed ☐ Separted ☒ Single ☐ Divorced
11. Number of Dependent Children 0
12. Spouse's Name n/a
13. Doctor's Name (seen for this injury)
14. Doctor's Mailing Address (Street or P.O. Box)
City State ZIP Code

15. Date of Injury (m-d-y) 1/12/02
16. Time of Injury 10:00 ☒ am ☐ pm
17. Date Lost Time Began (m-d-y) n/a
18. Nature of Injury* Exposure
19. Part of Body Injured or Exposed* body
20. How and Why Injury/Illness Occurred*
Handling infected patient, urine and bedding in patient cage. Dog positive for Leptospirosis.
21. Was Employee doing his regular job? ☒ YES ☐ NO
22. Worksite Location of Injury (stairs, dock, etc.)* Small animal ICU
23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site Vet Hosp
Street or P.O. Box County Brazos
City College Station State TX ZIP Code 77843
24. Cause of Injury (fall, tool, machine, etc.)* dog
25. List Witnesses
26. Return to work: ☐ Date ☐ Expected
27. Did Employee die? ☐ YES ☒ NO
28. Supervisor's Name Jessica Brier
29. Date Reported (m-d-y) 1/17/02

30. Date of Hire (m-d-y) 11/14/00
31. Was employee hired or recruited in Texas? ☒ YES ☐ NO
32. Length of Service in Current Position Months 2 Years 1
33. Length of Service in Occupation Months 2 Years 1
34. Employee Payroll Classification Code/Title Code 5065
35. Occupation of Injured Worker Vet Tech I
36. Rate of Pay at this Job $ 11.98 Hourly $ 479.70 Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $ 958.40 for 80 Hours or _____ Days
39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form Mary R. Smith SR HR Technician
41. Name of Business VTEA
42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone (409) 862-1720
City College Station State TX ZIP Code 77843-1255
43. Business location (if different from mailing address)
Number and Street MS 4457
City College Station State TX ZIP Code 77843-4457
44. Federal Tax Identification Number ☒ N/A
45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A
46. Specific SIC Code * (4 digit) ☒ N/A
47. Texas Comptroller Taxpayer No. ☒ N/A
48. Workers' Compensation Insurance Company The Texas A&M University System
49. Policy Number Self-Insured
50. Did you request accident prevention services in past 12 months? ☒ N/A ☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 1/24/2002
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last First M.I.)

2. Sex ☒ F ☐ M

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 8/16/76

6. Does the Employee Speak English? If No, Specify Language ☒ YES ☐ NO

7. Race ☒ White ☐ Black ☐ Asian

8. Ethnicity ☐ Hispanic ☐ Native American ☐ Other

9. Mailing Address
Street or P.O. Box

City State ZIP Code County

10. Marital Status ☐ Married ☐ Widowed ☐ Separted ☒ Single ☐ Divorced

11. Number of Dependent Children 0

12. Spouse's Name n/a

13. Doctor's Name (seen for this injury)

14. Doctor's Mailing Address (Street or P.O. Box)

City State ZIP Code

15. Date of Injury (m-d-y) 1/14/02

16. Time of Injury 11:00 ☒ am ☐ pm

17. Date Lost Time Began (m-d-y) n/a

18. Nature of Injury* Exposure

19. Part of Body Injured or Exposed* body

20. How and Why Injury/Illness Occurred*
Employee handled infected patient, urine, and bedding in patient cage. Patient positive for Leptospirosis.

21. Was Employee doing his regular job? ☒ YES ☐ NO

22. Worksite Location of Injury (stairs, dock, etc.)* Small animal ICU

23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site Bldg 1085
Street or P.O. Box County Brazos
City College Station State TX ZIP Code 77843

24. Cause of Injury (fall, tool, machine, etc.)* dog

25. List Witnesses none

26. Return to work: ☐ Date ☐ Expected

27. Did Employee die? ☐ YES ☒ NO

28. Supervisor's Name Jessica Brier

29. Date Reported (m-d-y) 1/17/02

30. Date of Hire (m-d-y) 10/26/01

31. Was employee hired or recruited in Texas? ☒ YES ☐ NO

32. Length of Service in Current Position Months 2 Years 0

33. Length of Service in Occupation Months 2 Years 0

34. Employee Payroll Classification Code/Title Code 5065

35. Occupation of Injured Worker Vet Tech I

36. Rate of Pay at this Job $ 11.98 Hourly $ 479.70 Weekly

37. Full Work Week is: 40 Hours 5 Days

38. Last Paycheck was: $ 958.40 for 80 Hours or _____ Days

39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form
Mary R. Smith SR HR Technician

41. Name of Business
VTEA

42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone (409) 862-1720
City College Station State TX ZIP Code 77843-1255

43. Business location (if different from mailing address)
Number and Street MS 4457
City College Station State TX ZIP Code 77843-4457

44. Federal Tax Identification Number ☒ N/A

45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A

46. Specific SIC Code * (4 digit) ☒ N/A

47. Texas Comptroller Taxpayer No. ☒ N/A

48. Workers' Compensation Insurance Company
The Texas A&M University System

49. Policy Number
Self-Insured

50. Did you request accident prevention services in past 12 months? ☒ N/A
☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 1/24/2002
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last First, M.I.)
2. Sex: ☒ F ☐ M
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y): 2/24/78
6. Does the Employee Speak English? If No, Specify Language: ☒ YES ☐ NO
7. Race: ☒ White ☐ Black ☐ Asian
8. Ethnicity: ☐ Hispanic ☐ Native American ☐ Other
9. Mailing Address Street or P.O. Box
City State ZIP Code County
10. Marital Status: ☐ Married ☐ Widowed ☐ Separted ☒ Single ☐ Divorced
11. Number of Dependent Children: 0
12. Spouse's Name: n/a
13. Doctor's Name (seen for this injury)
14. Doctor's Mailing Address (Street or P.O. Box)
City State ZIP Code

15. Date of Injury (m-d-y): 1/14/02
16. Time of Injury: 10:00 ☒ am ☐ pm
17. Date Lost Time Began (m-d-y): n/a
18. Nature of Injury*: Exposure
19. Part of Body Injured or Exposed*: body
20. How and Why Injury/Illness Occurred*: Employee handled infected patient, urine from patient, bedding in patient cage. Patient shown later to be positive for Leptospirosis
21. Was Employee doing his regular job? ☒ YES ☐ NO
22. Worksite Location of Injury (stairs, dock, etc.)*: cage area
23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site: Small Animal ICU
Street or P.O. Box County: Brazos
City: College Station State: TX ZIP Code: 77843
24. Cause of Injury (fall, tool, machine, etc.)*: dog
25. List Witnesses: none
26. Return to work: ☐ Date ☐ Expected
27. Did Employee die? ☐ YES ☒ NO
28. Supervisor's Name: Jessica Brier
29. Date Reported (m-d-y): 1/17/02

30. Date of Hire (m-d-y): 8/16/01
31. Was employee hired or recruited in Texas? ☒ YES ☐ NO
32. Length of Service in Current Position: Months 6 Years 1
33. Length of Service in Occupation: Months 6 Years 1
34. Employee Payroll Classification Code/Title Code: 7565
35. Occupation of Injured Worker: Vet Tech
36. Rate of Pay at this Job: $ 9.48 Hourly $ 189.80 Weekly
37. Full Work Week is: 20 Hours _____ Days
38. Last Paycheck was: $ 537.89 for 56.68 Hours or _____ Days
39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form: Mary R. Smith SR HR Technician
41. Name of Business: VTEA
42. Business Mailing Address and Telephone Number
Street or PO Box: MS 1255 Telephone: (409) 862-1720
City: College Station State: TX ZIP Code: 77843-1255
43. Business location (if different from mailing address)
Number and Street: MS 4457
City: College Station State: TX ZIP Code: 77843-4457
44. Federal Tax Identification Number: ☒ N/A
45. Primary Standard Industrial Classification SIC Code * (4 digit): ☒ N/A
46. Specific SIC Code * (4 digit): ☒ N/A
47. Texas Comptroller Taxpayer No.: ☒ N/A
48. Workers' Compensation Insurance Company: The Texas A&M University System
49. Policy Number: Self-Insured
50. Did you request accident prevention services in past 12 months? ☒ N/A
☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 1/24/2002
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

hy — Ep Exposure

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex ☐ F ☒ M

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 11/17/75

6. Does the Employee Speak English? If No, Specify Language ☒ YES ☐ NO

7. Race ☒ White ☐ Black ☐ Asian

8. Ethnicity ☐ Hispanic ☐ Other ☐ Native American

9. Mailing Address
Street or P.O. Box

City State ZIP Code County

10. Marital Status ☐ Married ☐ Widowed ☐ Separted ☒ Single ☐ Divorced

11. Number of Dependent Children 0

12. Spouse's Name n/a

13. Doctor's Name (seen for this injury)

14. Doctor's Mailing Address (Street or P.O. Box)

City State ZIP Code

15. Date of Injury (m-d-y) 2/04/02

16. Time of Injury 3:00 ☐ am ☒ pm

17. Date Lost Time Began (m-d-y) n/a

18. Nature of Injury* Exposure

19. Part of Body Injured or Exposed* Whole body

20. How and Why Injury/Illness Occurred*
Employee handled urine, and bedding from a dog found to be positive for Leptospirosis.

21. Was Employee doing his regular job? ☒ YES ☐ NO

22. Worksite Location of Injury (stairs, dock, etc.)* ICU

23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site Small Animal Clinic
Street or P.O. Box County Brazos
City College Station State TX ZIP Code 77843

24. Cause of Injury (fall, tool, machine, etc.)* dog

25. List Witnesses Robin Graham

26. Return to work: ☐ Date ☐ Expected

27. Did Employee die? ☐ YES ☒ NO

28. Supervisor's Name Jessica Brier

29. Date Reported (m-d-y) 2/10/02

30. Date of Hire (m-d-y) 10/09/01

31. Was employee hired or recruited in Texas? ☒ YES ☐ NO

32. Length of Service in Current Position Months 5 Years 0

33. Length of Service in Occupation Months 5 Years 0

34. Employee Payroll Classification Code/Title Code 5065

35. Occupation of Injured Worker ICU Tech I

36. Rate of Pay at this Job $ 11.98 Hourly $ 479.20 Weekly

37. Full Work Week is: 40 Hours 5 Days

38. Last Paycheck was: $ 958.40 for 80 Hours or ____ Days

39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form
Mary R. Smith, Employee Relations Representative

41. Name of Business
VTEA

42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone (979) 862-1720
City College Station State TX ZIP Code 77843-4457

43. Business location (if different from mailing address)
Number and Street MS 4457
City College Station State TX ZIP Code 77843-4457

44. Federal Tax Identification Number ☒ N/A

45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A

46. Specific SIC Code * (4 digit) ☒ N/A

47. Texas Comptroller Taxpayer No. ☒ N/A

48. Workers' Compensation Insurance Company
The Texas A&M University System

49. Policy Number
Self-Insured

50. Did you request accident prevention services in past 12 months? ☒ N/A
☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 2/27/2002
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

Exposure

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex ☒ F ☐ M

3. Social Security Number: 458-59-0610

4. Home Phone: 936/436-0765

5. Date of Birth (m-d-y): 11/16/70

6. Does the Employee Speak English? If No, Specify Language
☒ YES ☐ NO

7. Race ☒ White ☐ Black ☐ Asian

8. Ethnicity ☐ Hispanic ☐ Other ☐ Native American

9. Mailing Address
Street or P.O. Box

City State ZIP Code County

10. Marital Status
☐ Married ☐ Widowed ☐ Separted ☒ Single ☐ Divorced

11. Number of Dependent Children: 0

12. Spouse's Name: n/a

13. Doctor's Name (seen for this injury)

14. Doctor's Mailing Address (Street or P.O. Box)

City State ZIP Code

15. Date of Injury (m-d-y): 2/01/02

16. Time of Injury: 10:00 ☒ am ☐ pm

17. Date Lost Time Began (m-d-y): n/a

18. Nature of Injury*: Exposure

19. Part of Body Injured or Exposed*: whole body

20. How and Why Injury/Illness Occurred*
Employee was exposed to a dog that later was shown to be positive for Leptospirosis.

21. Was Employee doing his regular job? ☒ YES ☐ NO

22. Worksite Location of Injury (stairs, dock, etc.)*: ICU

23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site: Small Animal Clinic
Street or P.O. Box County: Brazos
City: College Station State: TX ZIP Code: 77843

24. Cause of Injury (fall, tool, machine, etc.)*: Dog

25. List Witnesses: none

26. Return to work: ☐ Date ☐ Expected

27. Did Employee die? ☐ YES ☒ NO

28. Supervisor's Name: Jessica Brier

29. Date Reported (m-d-y): 2/15/02

30. Date of Hire (m-d-y): 6/27/00

31. Was employee hired or recruited in Texas? ☒ YES ☐ NO

32. Length of Service in Current Position: Months 8 Years 1

33. Length of Service in Occupation: Months 8 Years 1

34. Employee Payroll Classification Code/Title Code: 5065

35. Occupation of Injured Worker: Vet Technician

36. Rate of Pay at this Job: $ 11.98 Hourly $ 479.20 Weekly

37. Full Work Week is: 40 Hours 5 Days

38. Last Paycheck was: $ 958.40 for 80 Hours or _____ Days

39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form: Mary R. Smith, Employee Relations Representative

41. Name of Business: VTEA

42. Business Mailing Address and Telephone Number
Street or PO Box: MS 1255 Telephone: (979) 862-1720
City: College Station State: TX ZIP Code: 77843-1255

43. Business location (if different from mailing address)
Number and Street: MS 4457
City: College Station State: TX ZIP Code: 77843-4457

44. Federal Tax Identification Number: ☒ N/A

45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A

46. Specific SIC Code * (4 digit) ☒ N/A

47. Texas Comptroller Taxpayer No. ☒ N/A

48. Workers' Compensation Insurance Company: The Texas A&M University System

49. Policy Number: Self-Insured

50. Did you request accident prevention services in past 12 months? ☒ N/A
☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 2/20/2002
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

Exposure

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.): M
2. Sex: ☐ F ☒ M
3. Social Security Number: 240-15-4413
4. Home Phone: 979/585-3123
5. Date of Birth (m-d-y): 04/06/62
6. Does the Employee Speak English? If No, Specify Language: ☒ YES ☐ NO
7. Race: ☒ White ☐ Black ☐ Asian
8. Ethnicity: ☐ Hispanic ☐ Native American ☐ Other
9. Mailing Address Street or P.O. Box
City State ZIP Code County
10. Marital Status: ☒ Married ☐ Widowed ☐ Separted ☐ Single ☐ Divorced
11. Number of Dependent Children: 1
12. Spouse's Name: Sharon Barker
13. Doctor's Name (seen for this injury)
14. Doctor's Mailing Address (Street or P.O. Box)
City State ZIP Code

15. Date of Injury (m-d-y): 1/12/02
16. Time of Injury: 10:00 ☐ am ☒ pm
17. Date Lost Time Began (m-d-y): n/a
18. Nature of Injury*: Exposure
19. Part of Body Injured or Exposed*: Whole Body
20. How and Why Injury/Illness Occurred*: Employee handled urine, and bedding from a patient infected with Leptospirosis.
21. Was Employee doing his regular job? ☒ YES ☐ NO
22. Worksite Location of Injury (stairs, dock, etc.)*: ICU
23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site: Small Animal
Street or P.O. Box
County: Brazos
City: College Station State: TX ZIP Code: 77843
24. Cause of Injury (fall, tool, machine, etc.)*: dog
25. List Witnesses: none
26. Return to work: ☐ Date ☐ Expected
27. Did Employee die? ☐ YES ☒ NO
28. Supervisor's Name: Jessica Brier
29. Date Reported (m-d-y): 1/17/02

30. Date of Hire (m-d-y): 1/18/01
31. Was employee hired or recruited in Texas? ☒ YES ☐ NO
32. Length of Service in Current Position: Months 7 Years 0
33. Length of Service in Occupation: Months 7 Years 0
34. Employee Payroll Classification Code/Title Code: 7563
35. Occupation of Injured Worker: ICU Technician
36. Rate of Pay at this Job: $ 9.49 Hourly $ 189.80 Weekly
37. Full Work Week is: 20 Hours ____ Days
38. Last Paycheck was: $ 75.92 for 8 Hours or ____ Days
39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form: Mary R. Smith, Employee Relations Representative
41. Name of Business: VTEA
42. Business Mailing Address and Telephone Number
Street or PO Box: MS 1255 Telephone: (979) 862-1720
City: College Station State: TX ZIP Code: 77843-1255
43. Business location (if different from mailing address)
Number and Street: MS 4457
City: College Station State: TX ZIP Code: 77843-4457
44. Federal Tax Identification Number: ☒ N/A
45. Primary Standard Industrial Classification SIC Code * (4 digit): ☒ N/A
46. Specific SIC Code * (4 digit): ☒ N/A
47. Texas Comptroller Taxpayer No.: ☒ N/A
48. Workers' Compensation Insurance Company: The Texas A&M University System
49. Policy Number: Self-Insured
50. Did you request accident prevention services in past 12 months? ☒ N/A ☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 2/28/2002
Authorized Signature of Supervisor

Exposure

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex ☐ F ☒ M
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y) 02/27/69
6. Does the Employee Speak English? If No, Specify Language ☒ YES ☐ NO
7. Race ☒ White ☐ Black ☐ Asian
8. Ethnicity ☐ Hispanic ☐ Other ☐ Native American
9. Mailing Address Street or P.O. Box
City State ZIP Code County
10. Marital Status ☐ Married ☐ Widowed ☐ Separted ☒ Single ☐ Divorced
11. Number of Dependent Children 2
12. Spouse's Name n/a
13. Doctor's Name (seen for this injury)
14. Doctor's Mailing Address (Street or P.O. Box)
City State ZIP Code

15. Date of Injury (m-d-y) 1/15/02
16. Time of Injury 2:00 ☐ am ☒ pm
17. Date Lost Time Began (m-d-y) n/a
18. Nature of Injury* Exposure
19. Part of Body Injured or Exposed* whole body
20. How and Why Injury/Illness Occurred* Employee was exposed while caring for a dog infected with Leptospirosis.
21. Was Employee doing his regular job? ☒ YES ☐ NO
22. Worksite Location of Injury (stairs, dock, etc.)* ICU
23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site Small animal hospital
Street or P.O. Box County Brazos
City College Station State TX ZIP Code 77843
24. Cause of Injury (fall, tool, machine, etc.)* dog
25. List Witnesses none
26. Return to work: ☐ Date ☐ Expected
27. Did Employee die? ☐ YES ☒ NO
28. Supervisor's Name Jessica Brier
29. Date Reported (m-d-y) 1/23/02

30. Date of Hire (m-d-y) 4/26/99
31. Was employee hired or recruited in Texas? ☒ YES ☐ NO
32. Length of Service in Current Position Months 10 Years 1
33. Length of Service in Occupation Months 10 Years 1
34. Employee Payroll Classification Code/Title Code 5076
35. Occupation of Injured Worker Lab Tech
36. Rate of Pay at this Job $ 9.18 Hourly $ 367.20 Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $ 734.40 for 80 Hours or _____ Days
39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form Mary R. Smith, Employee Relations Representative
41. Name of Business VTEA
42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone 979/862-1720
City College Station State TX ZIP Code 77843-1255
43. Business location (if different from mailing address)
Number and Street MS 4457
City College Station State TX ZIP Code 77843-4457
44. Federal Tax Identification Number ☒ N/A
45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A
46. Specific SIC Code * (4 digit) ☒ N/A
47. Texas Comptroller Taxpayer No. ☒ N/A
48. Workers' Compensation Insurance Company The Texas A&M University System
49. Policy Number Self-Insured
50. Did you request accident prevention services in past 12 months? ☒ N/A ☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Authorized Signature of Supervisor
2/28/2002

TWCC-1 (2-91)
2/13/91

Rule 120.2

Exposure -

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex ☒ F ☐ M

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 10/31/78

6. Does the Employee Speak English? If No, Specify Language ☒ YES ☐ NO

7. Race ☒ White ☐ Black ☐ Asian

8. Ethnicity ☐ Hispanic ☐ Native American ☐ Other

9. Mailing Address
Street or P.O. Box

City State ZIP Code County

10. Marital Status ☐ Married ☐ Widowed ☐ Separted ☒ Single ☐ Divorced

11. Number of Dependent Children 0

12. Spouse's Name n/a

13. Doctor's Name (seen for this injury)

14. Doctor's Mailing Address (Street or P.O. Box)

City State ZIP Code

15. Date of Injury (m-d-y) 2/03/02

16. Time of Injury 8:00 ☒ am ☐ pm

17. Date Lost Time Began (m-d-y) n/a

18. Nature of Injury* Exposure

19. Part of Body Injured or Exposed* Whole body

20. How and Why Injury/Illness Occurred*
Employee had contact with animal that later tested positive for Leptospirosis
urine, bedding, etc.

21. Was Employee doing his regular job? ☒ YES ☐ NO

22. Worksite Location of Injury (stairs, dock, etc.)* ICU

23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site Small Animal Clinic
Street or P.O. Box County Brazos
City College Station State TX ZIP Code 77843

24. Cause of Injury (fall, tool, machine, etc.)* dog

25. List Witnesses none

26. Return to work: ☐ Date ☐ Expected

27. Did Employee die? ☐ YES ☒ NO

28. Supervisor's Name Jessica Brier

29. Date Reported (m-d-y) 2/09/02

30. Date of Hire (m-d-y) 1/11/01

31. Was employee hired or recruited in Texas? ☒ YES ☐ NO

32. Length of Service in Current Position Months 1 Years 1

33. Length of Service in Occupation Months 1 Years 1

34. Employee Payroll Classification Code/Title Code 7561

35. Occupation of Injured Worker Vet Technician I

36. Rate of Pay at this Job $ 7.25 Hourly $ 287.28 Weekly

37. Full Work Week is: 40 Hours 56 Days

38. Last Paycheck was: $ 574.56 for 79.25 Hours or _____ Days

39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☐ NO

40. Name and Title of Person completing form
Mary R. Smith, Employee Relations Representative

41. Name of Business
VTEA

42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone (979) 862-1720
City College Station State TX ZIP Code 77843-1255

43. Business location (if different from mailing address)
Number and Street MS 4457
City College Station State TX ZIP Code 77843-4457

44. Federal Tax Identification Number ☒ N/A

45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A

46. Specific SIC Code * (4 digit) ☒ N/A

47. Texas Comptroller Taxpayer No. ☒ N/A

48. Workers' Compensation Insurance Company
The Texas A&M University System

49. Policy Number
Self-Insured

50. Did you request accident prevention services in past 12 months? ☒ N/A ☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 2/27/2002
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

Leptospirosis Exp

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex ☒ F ☐ M

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 8/31/79

6. Does the Employee Speak English? ☒ YES ☐ NO If No, Specify Language

7. Race ☒ White ☐ Black ☐ Asian

8. Ethnicity ☐ Hispanic ☐ Native American ☐ Other

9. Mailing Address
Street or P.O. Box

City State ZIP Code County

10. Marital Status
☐ Married ☐ Widowed ☐ Separted ☒ Single ☐ Divorced

11. Number of Dependent Children 0

12. Spouse's Name n/a

13. Doctor's Name (seen for this injury)

14. Doctor's Mailing Address (Street or P.O. Box)

City State ZIP Code

15. Date of Injury (m-d-y) 1/16/02

16. Time of Injury 2:00 ☒ am ☐ pm

17. Date Lost Time Began (m-d-y) n/a

18. Nature of Injury* Exposure

19. Part of Body Injured or Exposed* Body

20. How and Why Injury/Illness Occurred*
Employee was handling an infected patient, urine, and bedding from patient later to be found to be positive for Leptospirosis.

21. Was Employee doing his regular job? ☒ YES ☐ NO

22. Worksite Location of Injury (stairs, dock, etc.)* Small animal ICU

23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site Bldg. 1085
Street or P.O. Box County Brazos
City College Station State TX ZIP Code 77843

24. Cause of Injury (fall, tool, machine, etc.)* dog

25. List Witnesses none

26. Return to work: ☐ Date ☐ Expected

27. Did Employee die? ☐ YES ☒ NO

28. Supervisor's Name Jessical Brier

29. Date Reported (m-d-y) 2/12/02

30. Date of Hire (m-d-y) 10/23/01

31. Was employee hired or rceruited in Texas? ☒ YES ☐ NO

32. Length of Service in Current Position Months 3 Years 0

33. Length of Service in Occupation Months 3 Years 0

34. Employee Payroll Classification Code/Title Code 5065

35. Occupation of Injured Worker Tech I

36. Rate of Pay at this Job $ 11.98 Hourly $ 479.20 Weekly

37. Full Work Week is: 40 Hours 5 Days

38. Last Paycheck was: $ 958.40 for 80 Hours or _____ Days

39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form
Mary R. Smith, Employee Relations Representative

41. Name of Business
VTEA

42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone (409) 862-1720
City College Station State TX ZIP Code 77843-1255

43. Business location (if different from mailing address)
Number and Street MS 4457
City College Station State TX ZIP Code 77843-4457

44. Federal Tax Identification Number ☒ N/A

45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A

46. Specific SIC Code * (4 digit) ☒ N/A

47. Texas Comptroller Taxpayer No. ☒ N/A

48. Workers' Compensation Insurance Company
The Texas A&M University System

49. Policy Number
Self-Insured

50. Did you request accident prevention services in past 12 months? ☒ N/A
☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 2/12/2002
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

717

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☑ M ☐

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 05 - 27 - 1983

6. Does the Employee Speak English? If No, Specify Language
YES ☑ NO ☐

7. Race White ☐ Black ☐ Asian ☐

8. Ethnicity Hispanic ☑ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☑ Divorced ☐

11. Number of Dependent Children: N/A

12. Spouse's Name

13. Doctor's Name: TAMU Health center/Scott & White

14. Doctor's Mailing Address (Street or P.O.Box)

City State Zip Code

15. Date of Injury (m-d-y): 04 12 06

16. Time of Injury: 0 0 am ☐ pm ☐

17. Date Last Time Began (m-d-y) N-L-T

18. Nature of Injury*: Fungal Exposure

19. Part of Body Injured or Exposed*: Systemic

20. How and Why Injury/Illness Occurred*: Possible exposure to histoplasma

21. Was employee doing his regular job? YES ☑ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)*: TAMU Clinical Micro Lab

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site
TAMU - Small Animal Clinic
Street or P.O. Box: UNIVERSITY DR. BLDG. 508
County: BRAZOS
City: COLLEGE STATION State: TX Zip Code: 77843-4457

24. Cause of Injury(fall, tool, machine, etc.)*: Fungal exposure

25. List Witnesses: Dr. Melissa Libal

26. Return to work date/or expected (m-d-y): 04 12 2006

27. Did employee die? YES ☐ NO ☑

28. Supervisor's Name: Dr. Libal

29. Date Reported (m-d-y): 04 26 06

30. Date of Hire (m-d-y): 09 26 2006

31. Was employee hired or recruited in Texas? YES ☑ NO ☐

32. Length of Service in Current Position: Months 7 Years 0

33. Length of Service in Occupation: Months 7 Years

34. Employee Payroll Classification Code: 7565

35. Occupation of Injured Worker: Lab Tech I

36. Rate of Pay at this Job: $10.50 Hourly $ 40 Weekly

37. Full Work Week is: 40 Hours 7 Days

38. Last Paycheck was: $ 620.0 for 40 Hours or 10 Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form: Meriwyn Shivers

41. Name of Business: TEXAS A&M UNIVERSITY- VET. MED. TEACH. HOSP.

42. Business Mailing Address and Telephone Number
Street or P.O. Box: UNIVERSITY DR. BLDG. 508
Telephone: (979) 862-1317
City: COLLEGE STATION State: TX Zip Code: 77843-4457

43. Business Location (if different from mailing address)
Number and Street: 1111 RESEARCH PARKWAY 77843-1255
City State Zip Code

44. Federal Tax Identification Number: 74-6000-531

45. Primary North American Industry Classification System Code: (6 digit) XXXX

46. Specific NAICS Code (6 digit) XXXX

47. Texas Comptroller Taxpayer No. XXXX

48. Workers' Compensation Insurance Company: TAMU- RISK MANAGMENT & SAFETY

49. Policy Number: SELF INSURED

50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X Meriwyn Shivers Date 05/01/2006

718

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☑ M ☐

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 07 . 12 . 1982

6. Does the Employee Speak English? If No, Specify Language
YES ☑ NO ☐

7. Race White ☑ Black ☐ Asian ☐

8. Ethnicity Hispanic ☐ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☑ Divorced ☐

11. Number of Dependent Children
N/A

12. Spouse's Name

13. Doctor's Name
TAMU Health center/Scott & White

14. Doctor's Mailing Address (Street or P.O.Box)

City State Zip Code

15. Date of Injury (m-d-y) 04 12 06

16. Time of Injury 0 :0 am ☐ pm ☐

17. Date Lost Time Began (m-d-y) N-L-T

18. Nature of Injury*
Fungal Exposure

19. Part of Body Injured or Exposed*
Systemic

20. How and Why Injury/Illness Occurred*
Possible exposure to histoplasma

21. Was employee doing his regular job? YES ☑ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)*
TAMU Clinical Micro Lab

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site
TAMU - Small Animal Clinic
Street or P.O. Box
UNIVERSITY DR. BLDG. 508
County
BRAZOS
City
COLLEGE STATION
State
TX
Zip Code
77843-4457

24. Cause of Injury(fall, tool, machine, etc.)*
Fungal exposure

25. List Witnesses
Dr. Melissa Libal

26. Return to work date/or expected (m-d-y) 04 12 2006

27. Did employee die? YES ☐ NO ☐

28. Supervisor's Name
Dr. Libal

29. Date Reported (m-d-y) 04 26 06

30. Date of Hire (m-d-y) 05 15 2005

31. Was employee hired or recruited in Texas? YES ☐ NO ☐

32. Length of Service in Current Position Months 5 Years 1

33. Length of Service in Occupation Months 0 Years 1

34. Employee Payroll Classification Code
7561

35. Occupation of Injured Worker
Small Animal - Student Worker I

36. Rate of Pay at this Job $ 8.50 Hourly $ 340 Weekly

37. Full Work Week is: 40 Hours 7 Days

38. Last Paycheck was: $ 312.0 for 46 Hours or 10 Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☐

40. Name and Title of Person Completing Form
Meriwyn Shivers

41. Name of Business
TEXAS A&M UNIVERSITY- VET. MED. TEACH. HOSP.

42. Business Mailing Address and Telephone Number
Street or P.O. Box
UNIVERSITY DR. BLDG. 508
Telephone
(979) 862-1317
City
COLLEGE STATION
State
TX
Zip Code
77843-4457

43. Business Location (if different from mailing address)
Number and Street
1111 RESEARCH PARKWAY 77843-1255
City State Zip Code

44. Federal Tax Identification Number
74-6000-531

45. Primary North American Industry Classification System Code (6 digit) XXXX

46. Specific NAICS Code (6 digit) XXXX

47. Texas Comptroller Taxpayer No.
XXXX

48. Workers' Compensation Insurance Company
TAMU- RISK MANAGMENT & SAFETY

49. Policy Number
SELF INSURED

50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X Meriwyn Shivers Date 05/01/2006

719

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☑ M ☐

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 08 - 29 - 1953

6. Does the Employee Speak English? YES ☑ NO ☐ If No, Specify Language

7. Race White ☑ Black ☐ Asian ☐

8. Ethnicity Hispanic ☑ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☑ Divorced ☐

11. Number of Dependent Children: N/A

12. Spouse's Name: N/A

13. Doctor's Name: Dr. Wegner

14. Doctor's Mailing Address (Street or P.O.Box): 1600 University Drive East

City: College Station State: TX Zip Code: 77840

15. Date of Injury (m-d-y): 04 12 06

16. Time of Injury: 0 0 am ☐ pm ☐

17. Date Last Time Began (m-d-y) N-L-T

18. Nature of Injury*: Fungal Exposure

19. Part of Body Injured or Exposed*: Systemic

20. How and Why Injury/Illness Occurred*: Possible exposure to histoplasma

21. Was employee doing his regular job? YES ☑ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)*: TAMU Clinical Micro Lab

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site: TAMU - Small Animal Clinic

Street or P.O. Box: UNIVERSITY DR. BLDG. 508 County: BRAZOS

City: COLLEGE STATION State: TX Zip Code: 77843-4457

24. Cause of Injury(fall, tool, machine, etc.)*: Fungal exposure

25. List Witnesses: Dr. Melissa Libal

26. Return to work date/or expected (m-d-y): 04 12 2006

27. Did employee die? YES ☐ NO ☑

28. Supervisor's Name: Dr. Libal

29. Date Reported (m-d-y): 04 28 06

30. Date of Hire (m-d-y): 09 09 1982

31. Was employee hired or recruited in Texas? YES ☑ NO ☐

32. Length of Service in Current Position: Months 2 Years 1

33. Length of Service in Occupation: Months 0 Years 24

34. Employee Payroll Classification Code: 9241

35. Occupation of Injured Worker: Technical Laboratory Coordinator

36. Rate of Pay at this Job: $18.60 Hourly $585. Weekly

37. Full Work Week is: 40 Hours 7 Days

38. Last Paycheck was: $2942. for Hours or 21 Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form: Meriwyn Shivers

41. Name of Business: TEXAS A&M UNIVERSITY- VET. MED. TEACH. HOSP.

42. Business Mailing Address and Telephone Number

Street or P.O. Box: UNIVERSITY DR. BLDG. 508 Telephone: (979) 862-1317

City: COLLEGE STATION State: TX Zip Code: 77843-4457

43. Business Location (if different from mailing address) Number and Street: 1111 RESEARCH PARKWAY 77843-1256

City State Zip Code

44. Federal Tax Identification Number: 74-6000-531

45. Primary North American Industry Classification System Code: (6 digit) XXXX

46. Specific NAICS Code (6 digit) XXXX

47. Texas Comptroller Taxpayer No. XXXX

48. Workers' Compensation Insurance Company: TAMU- RISK MANAGMENT & SAFETY

49. Policy Number: SELF INSURED

50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)

X Meriwyn Shivers Date 05/01/2006

720

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☑ M ☐

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 11-09-1948

6. Does the Employee Speak English? YES ☑ NO ☐ If No, Specify Language

7. Race White ☑ Black ☐ Asian ☐

8. Ethnicity Hispanic ☑ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status Married ☑ Widowed ☐ Separated ☐ Single ☐ Divorced ☐

11. Number of Dependent Children: N/A

12. Spouse's Name: George

13. Doctor's Name: Dr. Jose - Scott and White

14. Doctor's Mailing Address (Street or P.O.Box): 1600 University Drive East

City: College Station State: TX Zip Code: 77840

15. Date of Injury (m-d-y): 04 12 06

16. Time of Injury: 0 0 am ☐ pm ☐

17. Date Lost Time Began (m-d-y) N-L-T -

18. Nature of Injury*: Potential

19. Part of Body Injured or Exposed*: Systemic

20. How and Why Injury/Illness Occurred*: Possible exposure to histoplasma

21. Was employee doing his regular job? YES ☑ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)*: VMTH 2015

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site: TAMU - Small Animal Clinic

Street or P.O. Box: UNIVERSITY DR. BLDG. 508 County: BRAZOS

City: COLLEGE STATION State: TX Zip Code: 77843-4457

24. Cause of Injury(fall, tool, machine, etc.)*: potential exposure

25. List Witnesses: Dr. Melissa Libal

26. Return to work date/or expected (m-d-y): none lost

27. Did employee die? YES ☐ NO ☑

28. Supervisor's Name: Dr. Libal

29. Date Reported (m-d-y): 04 26 06

30. Date of Hire (m-d-y): 07 01 1998

31. Was employee hired or recruited in Texas? YES ☐ NO ☑

32. Length of Service in Current Position: Months 18 Years 0

33. Length of Service in Occupation: Months 0 Years 29

34. Employee Payroll Classification Code

35. Occupation of Injured Worker: Veterinarian

36. Rate of Pay at this Job: $ Hourly $ Weekly

37. Full Work Week is: 40 Hours 7 Days

38. Last Paycheck was: $4800. for Hours or 21 Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form: Merlwyn Shivers

41. Name of Business: TEXAS A&M UNIVERSITY- VET. MED. TEACH. HOSP.

42. Business Mailing Address and Telephone Number
Street or P.O. Box: UNIVERSITY DR. BLDG. 508 Telephone: (979) 862-1317

City: COLLEGE STATION State: TX Zip Code: 77643-4457

43. Business Location (if different from mailing address)
Number and Street: 1111 RESEARCH PARKWAY 77843-1255

City State Zip Code

44. Federal Tax Identification Number: 74-6000-531

45. Primary North American Industry Classification System Code: (6 digit) XXXX

46. Specific NAICS Code (6 digit) XXXX

47. Texas Comptroller Taxpayer No.: XXXX

48. Workers' Compensation Insurance Company: TAMU: RISK MANAGMENT & SAFETY

49. Policy Number: SELF INSURED

50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)

X Merlwyn Shivers Date 05/01/2006

121

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☑ M ☐

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 10 - 22 - 1982

6. Does the Employee Speak English? If No, Specify Language
YES ☑ NO ☐

7. Race White ☑ Black ☐ Asian ☐

8. Ethnicity Hispanic ☑ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☑ Divorced ☐

11. Number of Dependent Children: N/A

12. Spouse's Name: N/A

13. Doctor's Name: N/A

14. Doctor's Mailing Address (Street or P.O.Box): N/A

City State Zip Code

15. Date of Injury (m-d-y): 04 12 06

16. Time of Injury: 0 :0 am ☐ pm ☐

17. Date Lost Time Began (m-d-y) N-L-T -

18. Nature of Injury*: Histoplasma

19. Part of Body Injured or Exposed*: Systemic

20. How and Why Injury/Illness Occurred*: Possible exposure to histoplasma

21. Was employee doing his regular job? YES ☑ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)*: Micro Lab

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site
TAMU - Small Animal Clinic
Street or P.O. Box: UNIVERSITY DR. BLDG. 508
County: BRAZOS
City: COLLEGE STATION State: TX Zip Code: 77843-4457

24. Cause of Injury(fall, tool, machine, etc.)*: potential exposure

25. List Witnesses: Dr. Melisse Libal

26. Return to work date/or expected (m-d-y): none lost

27. Did employee die? YES ☐ NO ☑

28. Supervisor's Name: Dr. Libal

29. Date Reported (m-d-y): 04 27 06

30. Date of Hire (m-d-y): 03 20 2006

31. Was employee hired or recruited in Texas? YES ☑ NO ☐

32. Length of Service in Current Position: Months 1 Years 0

33. Length of Service in Occupation: Months 1 Years

34. Employee Payroll Classification Code: 5005

35. Occupation of Injured Worker: Vet Tech I

36. Rate of Pay at this Job: $10.15 Hourly $ Weekly

37. Full Work Week is: 40 Hours 5 Days

38. Last Paycheck was: $327.0 for 80 Hours or 10 Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form: Meriwyn Shivers

41. Name of Business: TEXAS A&M UNIVERSITY- VET. MED. TEACH. HOSP.

42. Business Mailing Address and Telephone Number
Street or P.O. Box: UNIVERSITY DR. BLDG. 508
Telephone: (979) 862-1317
City: COLLEGE STATION State: TX Zip Code: 77843-4457

43. Business Location (if different from mailing address) Number and Street: 1111 RESEARCH PARKWAY 77843-1255
City State Zip Code

44. Federal Tax Identification Number: 74-6000-531

45. Primary North American Industry Classification System Code:(6 digit) XXXX

46. Specific NAICS Code (6 digit) XXXX

47. Texas Comptroller Taxpayer No.: xxxx

48. Workers' Compensation Insurance Company: TAMU- RISK MANAGMENT & SAFETY

49. Policy Number: SELF INSURED

50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X Meriwyn Shivers Date 05/01/2006

Rosy Gonzolas

722

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☑ M ☐

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 06 - 05 - 1959

6. Does the Employee Speak English? If No, Specify Language
YES ☑ NO ☐

7. Race White ☑ Black ☐ Asian ☐

8. Ethnicity Hispanic ☑ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status Married ☑ Widowed ☐ Separated ☐ Single ☐ Divorced ☐

11. Number of Dependent Children: 3

12. Spouse's Name: Andrew

13. Doctor's Name: Dr. Russel Biles

14. Doctor's Mailing Address (Street or P.O.Box): 1600 University Drive East

City: College Station State: TX Zip Code: 778840

15. Date of Injury (m-d-y): 04 12 06

16. Time of Injury: 0 :0 am ☐ pm ☐

17. Date Lost Time Began (m-d-y): N-L-T

18. Nature of Injury*: Fungal Exposure

19. Part of Body Injured or Exposed*: Systemic

20. How and Why Injury/Illness Occurred*: Possible exposure to histoplasma

21. Was employee doing his regular job? YES ☑ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)*: TAMU Clinical Micro Lab

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site
TAMU - Small Animal Clinic
Street or P.O. Box: UNIVERSITY DR. BLDG. 508
County: BRAZOS
City: COLLEGE STATION State: TX Zip Code: 77843-4457

24. Cause of Injury(fall, tool, machine, etc.)*: Fungal exposure

25. List Witnesses: Dr. Melissa Libal

26. Return to work date/or expected (m-d-y): 04 12 2006

27. Did employee die? YES ☐ NO ☑

28. Supervisor's Name: Dr. Libal

29. Date Reported (m-d-y): 04 27 06

30. Date of Hire (m-d-y): 05 21 1984

31. Was employee hired or recruited in Texas? YES ☑ NO ☐

32. Length of Service in Current Position: Months 11 Years 16

33. Length of Service in Occupation: Months 9 Years 20

34. Employee Payroll Classification Code: 5073

35. Occupation of Injured Worker: Med Tech

36. Rate of Pay at this Job: $ Hourly $677 Weekly

37. Full Work Week is: 40 Hours Days

38. Last Paycheck was: $2707 for Hours or 30 Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form: Merlwyn Shivers

41. Name of Business: TEXAS A&M UNIVERSITY- VET. MED. TEACH. HOSP.

42. Business Mailing Address and Telephone Number
Street or P.O. Box: UNIVERSITY DR. BLDG. 508
Telephone: (979) 862-1317
City: COLLEGE STATION State: TX Zip Code: 77843-4457

43. Business Location (if different from mailing address)
Number and Street: 1111 RESEARCH PARKWAY 77843-1255
City State Zip Code

44. Federal Tax Identification Number: 74-6000-531

45. Primary North American Industry Classification System Code: (6 digit) XXXX

46. Specific NAICS Code (6 digit): XXXX

47. Texas Comptroller Taxpayer No.: XXXX

48. Workers' Compensation Insurance Company: TAMU- RISK MANAGMENT & SAFETY

49. Policy Number: SELF INSURED

50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date 05/01/2006

645

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☑ M ☐

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 08 - 28 - 53

6. Does the Employee Speak English? YES ☑ NO ☐ If No, Specify Language

7. Race White ☑ Black ☐ Asian ☐

8. Ethnicity Hispanic ☑ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☑ Divorced ☐

11. Number of Dependent Children

12. Spouse's Name

13. Doctor's Name
DR. K. WEGNER

14. Doctor's Mailing Address (Street or P.O.Box)
1600 UNIVERSITY DRIVE E

City State Zip Code
COLLEGE STATION TX 77840

15. Date of Injury (m-d-y) 02 . 22 . 07

16. Time of Injury : am ☑ pm ☐

17. Date Last Time Began (m-d-y) N .L .T

18. Nature of Injury*
potential exposure

19. Part of Body Injured or Exposed*
entire body to histoplasma (systemic fungus)

20. How and Why Injury/Illness Occurred*
HANDLING CULTURE IN LAB, POTENTIAL EXPOSURE TO FUNGI ISOLATED IN LAB

21. Was employee doing his regular job? YES ☑ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)*
SAC CLINICAL MICROBIOLOGY LAB

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site
VMTH-SAC
Street or P.O. Box
UNIVERSITY DR. BLDG. 508
County
BRAZOS
City State Zip Code
COLLEGE STATION TX 77843-4457

24. Cause of Injury(fall, tool, machine, etc.)*
HANDLING CULTURE

25. List Witnesses
DR. MELISSA LIBAL

26. Return to work date/or expected (m-d-y)

27. Did employee die? YES ☐ NO ☑

28. Supervisor's Name
DR. MELISSA LIBAL

29. Date Reported (m-d-y) 02 . 22 . 07

30. Date of Hire (m-d-y) 02 . 20 . 92

31. Was employee hired or recruited in Texas? YES ☑ NO ☐

32. Length of Service in Current Position Months ____ Years 15

33. Length of Service in Occupation Months ____ Years 15

34. Employee Payroll Classification Code
9241

35. Occupation of Injured Worker
TECHNICAL LAB COORDINATOR

36. Rate of Pay at this Job
$3030.00 monthly Hourly $____ Weekly

37. Full Work Week is:
40 Hours 5 Days

38. Last Paycheck was:
$3030.00 monthly for ____ Hours or 30 Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form
SHERRY HADDIX- BUSINESS ASSOCIATE II

41. Name of Business
TEXAS A&M UNIVERSITY- VET. MED. TEACH. HOSP.

42. Business Mailing Address and Telephone Number
Street or P.O. Box
UNIVERSITY DR. BLDG. 508
Telephone
(979) 845-9107
City State Zip Code
COLLEGE STATION TX 77843-4457

43. Business Location (if different from mailing address)
Number and Street
City State Zip Code

44. Federal Tax Identification Number
74-6000-531

45. Primary North American Industry Classification System Code: (6 digit) xxxx

46. Specific NAICS Code (6 digit) xxxx

47. Texas Comptroller Taxpayer No. xxxx

48. Workers' Compensation Insurance Company
TAMU- RISK MANAGMENT & SAFETY

49. Policy Number
SELF INSURED

50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Business Assoc II Date 2-23-07

TEXAS WORKERS' COMPENSATION COMMISSION

02/23/2007 15:23 9798456226 VMTH ADMIN PAGE 03/07

646

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☐ M ☑

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 10 - 22 -82

6. Does the Employee Speak English? YES ☑ NO ☐ If No, Specify Language

7. Race White ☑ Black ☐ Asian ☐

8. Ethnicity Hispanic ☑ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☑ Divorced ☐

11. Number of Dependent Children: 0

12. Spouse's Name: N/A

13. Doctor's Name

14. Doctor's Mailing Address (Street or P.O.Box)

City State Zip Code

15. Date of Injury (m-d-y): 02 22 07

16. Time of Injury: : am ☑ pm ☐

17. Date Lost Time Began (m-d-y): N -L -T

18. Nature of Injury*: potential exposure

19. Part of Body Injured or Exposed*: entire body to histoplasma (systemic fungus)

20. How and Why Injury/Illness Occurred*: HANDLING CULTURE IN LAB, POTENTIAL EXPOSURE TO FUNGI ISOLATED IN LAB

21. Was employee doing his regular job? YES ☑ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)*: SAC CLINICAL MICROBIOLOGY LAB

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site: VMTH-SAC
Street or P.O. Box: UNIVERSITY DR. BLDG. 508
County: BRAZOS
City: COLLEGE STATION
State: TX
Zip Code: 77843-4457

24. Cause of Injury(fall, tool, machine, etc.)*: HANDLING CULTURE

25. List Witnesses: DR. LIBAL

26. Return to work date/or expected (m-d-y):

27. Did employee die? YES ☐ NO ☑

28. Supervisor's Name: ROSIE GONZALEZ

29. Date Reported (m-d-y): 02 22 07

30. Date of Hire (m-d-y): 03 20 2006

31. Was employee hired or recruited in Texas? YES ☑ NO ☐

32. Length of Service in Current Position: Months 11 Years

33. Length of Service in Occupation: Months 11 Years

34. Employee Payroll Classification Code: 5005

35. Occupation of Injured Worker: VET TECH I

36. Rate of Pay at this Job: $10.84 Hourly $ Weekly

37. Full Work Week is: 40 Hours 5 Days

38. Last Paycheck was: $887.20 for 80 Hours or 10 Days

38. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form: SHERRY HADDIX- BUSINESS ASSOCIATE II

41. Name of Business: TEXAS A&M UNIVERSITY- VET. MED. TEACH. HOSP.

42. Business Mailing Address and Telephone Number
Street or P.O. Box: UNIVERSITY DR. BLDG. 508
Telephone: (979) 845-9107
City: COLLEGE STATION
State: TX
Zip Code: 77843-4457

43. Business Location (If different from mailing address)
Number and Street
City State Zip Code

44. Federal Tax Identification Number: 74-6000-531

45. Primary North American Industry Classification System Code:(6 digit) XXXX

46. Specific NAICS Code (6 digit) XXXX

47. Texas Comptroller Taxpayer No. XXXX

48. Workers' Compensation Insurance Company: TAMU- RISK MANAGMENT & SAFETY

49. Policy Number: SELF INSURED

50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X Business Assoc. II Date 2-23-07

TEXAS WORKERS' COMPENSATION COMMISSION

02/23/2007 15:23 9798456226 VMTH ADMIN PAGE 05/07

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.

647

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)	2. Sex F ☑ M ☐	15. Date of Injury (m-d-y) 02 22 07	16. Time of Injury : am ☑ pm ☐ / 17. Date Lost Time Began (m-d-y) N .L .T
3. Social Security Number / 4. Home Phone	5. Date of Birth (m-d-y) 05 - 27 - 83	18. Nature of Injury* potential exposure	19. Part of Body Injured or Exposed* entire body to histoplasma (systemic fungus)
6. Does the Employee Speak English? YES ☑ NO ☐ If No, Specify Language		20. How and Why Injury/Illness Occurred* HANDLING CULTURE IN LAB, POTENTIAL EXPOSURE TO FUNGI ISOLATED IN LAB	
7. Race White ☑ Black ☐ Asian ☐	8. Ethnicity Hispanic ☑ Native American ☐ Other ☐	21. Was employee doing his regular job? YES ☑ NO ☐	22. Worksite Location of Injury (stairs, dock, etc.)* SAC CLINICAL MICROBIOLOGY LAB
9. Mailing Address Street or P.O. Box / City / State / Zip Code / County		23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site VMTH-SAC / Street or P.O. Box UNIVERSITY DR. BLDG. 508 / County BRAZOS / City COLLEGE STATION / State TX / Zip Code 77843-4457	
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☑ Divorced ☐		24. Cause of Injury(fall, tool, machine, etc.)* HANDLING CULTURE	
11. Number of Dependent Children / 12. Spouse's Name		25. List Witnesses ROSA GONZALES	
13. Doctor's Name		26. Return to work date/or expected (m-d-y)	27. Did employee die? YES ☐ NO ☑ / 28. Supervisor's Name ROSA GONZALEZ / 29. Date Reported (m-d-y) 02 22 07
14. Doctor's Mailing Address (Street or P.O.Box) 1600 UNIVERSITY DRIVE E / City COLLEGE STATION / State TX / Zip Code 77840			

30. Date of Hire (m-d-y) 09 01 05	31. Was employee hired or recruited in Texas? YES ☑ NO ☐	32. Length of Service in Current Position Months 5 Years 2	33. Length of Service in Occupation Months 5 Years 29
34. Employee Payroll Classification Code 5005	35. Occupation of Injured Worker VET TECH I		
36. Rate of Pay at this Job $10.84 Hourly $ ____ Weekly	37. Full Work Week is: 40 Hours 5 Days	38. Last Paycheck was: $867.20 for ____ Hours or ____ Days	39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form SHERRY HADDIX- BUSINESS ASSOCIATE II		41. Name of Business TEXAS A&M UNIVERSITY- VET. MED. TEACH. HOSP.	
42. Business Mailing Address and Telephone Number Street or P.O. Box UNIVERSITY DR. BLDG. 508 / Telephone (979) 845-9107 / City COLLEGE STATION / State TX / Zip Code 77843-4457		43. Business Location (if different from mailing address) Number and Street / City / State / Zip Code	
44. Federal Tax Identification Number 74-6000-531	45. Primary North American Industry Classification System Code: (6 digit) XXXX	46. Specific NAICS Code (6 digit) XXXX	47. Texas Comptroller Taxpayer No. XXXX
48. Workers' Compensation Insurance Company TAMU- RISK MANAGMENT & SAFETY		49. Policy Number SELF INSURED	

50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING) X Business Associate II Date 2-23-07

TEXAS WORKERS' COMPENSATION COMMISSION

02/23/2007 15:23 9798456226 VMTH ADMIN PAGE 04/07

648

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☑ M ☐

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 11 - 09 - 48

6. Does the Employee Speak English? YES ☑ NO ☐ If No, Specify Language

7. Race White ☑ Black ☐ Asian ☐

8. Ethnicity Hispanic ☐ Native American ☐ Other ☑

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status Married ☑ Widowed ☐ Separated ☐ Single ☐ Divorced ☐

11. Number of Dependent Children

12. Spouse's Name GEORGE

13. Doctor's Name DR. HAKETHORNE

14. Doctor's Mailing Address (Street or P.O.Box) 1600 UNIVERSITY DRIVE E

City COLLEGE STATION State TX Zip Code 77840

15. Date of Injury (m-d-y) 02 22 07

16. Time of Injury : am ☑ pm ☐

17. Date Lost Time Began (m-d-y) N L T

18. Nature of Injury* potential exposure

19. Part of Body Injured or Exposed* entire body to histoplasma (systemic fungus)

20. How and Why Injury/Illness Occurred* HANDLING CULTURE IN LAB, POTENTIAL EXPOSURE TO FUNGI ISOLATED IN LAB

21. Was employee doing his regular job? YES ☑ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)* SAC CLINICAL MICROBIOLOGY LAB

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site VMTH-SAC

Street or P.O. Box UNIVERSITY DR. BLDG. 508 County BRAZOS

City COLLEGE STATION State TX Zip Code 77843-4457

24. Cause of Injury(fall, tool, machine, etc.)* HANDLING CULTURE

25. List Witnesses ROSA GONZALES

26. Return to work date/or expected (m-d-y)

27. Did employee die? YES ☐ NO ☑

28. Supervisor's Name

29. Date Reported (m-d-y) 02 22 07

30. Date of Hire (m-d-y) 11 08 04

31. Was employee hired or recruited in Texas? YES ☑ NO ☐

32. Length of Service in Current Position Months 3 Years 2

33. Length of Service in Occupation Months 3 Years 3

34. Employee Payroll Classification Code 7664

35. Occupation of Injured Worker VETERINARIAN

36. Rate of Pay at this Job $8333.00 Monthly Hourly $ Weekly

37. Full Work Week is: 40 Hours 5 Days

38. Last Paycheck was: $8333.00 Monthly for Hours or Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form SHERRY HADDIX- BUSINESS ASSOCIATE II

41. Name of Business TEXAS A&M UNIVERSITY- VET. MED. TEACH. HOSP.

42. Business Mailing Address and Telephone Number Street or P.O. Box UNIVERSITY DR. BLDG. 508 Telephone (979) 845-9107

City COLLEGE STATION State TX Zip Code 77843-4457

43. Business Location (If different from mailing address) Number and Street

City State Zip Code

44. Federal Tax Identification Number 74-6000-531

45. Primary North American Industry Classification System Code: (6 digit) XXXX

45. Specific NAICS Code (6 digit) XXXX

47. Texas Comptroller Taxpayer No. XXXX

48. Workers' Compensation Insurance Company TAMU- RISK MANAGMENT & SAFETY

49. Policy Number SELF INSURED

50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING) X [signature] - Business Assoc. II Date 2-23-07

TEXAS WORKERS' COMPENSATION COMMISSION

02/23/2007 15:23 9798456226 VMTH ADMIN PAGE 02/07

649

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☑ M ☐

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 06 - 05 -59

6. Does the Employee Speak English? YES ☑ NO ☐ If No, Specify Language

7. Race White ☑ Black ☐ Asian ☐

8. Ethnicity Hispanic ☐ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

City State Zip Code County

10. Marital Status Married ☑ Widowed ☐ Separated ☐ Single ☐ Divorced ☐

11. Number of Dependent Children: 3

12. Spouse's Name: ANDREW

13. Doctor's Name: DR. RUSSEL BILES

14. Doctor's Mailing Address (Street or P.O.Box): 1600 UNIVERSITY DRIVE E

City: COLLEGE STATION State: TX Zip Code: 77840

15. Date of Injury (m-d-y): 02 . 22 . 07

16. Time of Injury: : am ☑ pm ☐

17. Date Lost Time Began (m-d-y): N . L . T

18. Nature of Injury*: potential exposure

19. Part of Body Injured or Exposed*: entire body to histoplasma (systemic fungus)

20. How and Why Injury/Illness Occurred*: HANDLING CULTURE IN LAB, POTENTIAL EXPOSURE TO FUNGI ISOLATED IN LAB

21. Was employee doing his regular job? YES ☑ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)*: SAC CLINICAL MICROBIOLOGY LAB

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site: VMTH-SAC

Street or P.O. Box: UNIVERSITY DR. BLDG. 508 County: BRAZOS

City: COLLEGE STATION State: TX Zip Code: 77843-4457

24. Cause of Injury(fall, tool, machine, etc.)*: HANDLING CULTURE

25. List Witnesses: DR. LIBAL

26. Return to work date/or expected (m-d-y):

27. Did employee die? YES ☐ NO ☑

28. Supervisor's Name: ROSIE GONZALEZ

29. Date Reported (m-d-y): 02 . 22 . 07

30. Date of Hire (m-d-y): 08 . 15 . 88

31. Was employee hired or recruited in Texas? YES ☑ NO ☐

32. Length of Service in Current Position: Months 6 Years 18

33. Length of Service in Occupation: Months 6 Years 18

34. Employee Payroll Classification Code: 5073

35. Occupation of Injured Worker: MEDICAL TECHNICIAN

36. Rate of Pay at this Job: $16.03 Hourly $ Weekly

37. Full Work Week is: 40 Hours 5 Days

38. Last Paycheck was: $1282.00 for 80 Hours or 10 Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form: SHERRY HADDIX- BUSINESS ASSOCIATE II

41. Name of Business: TEXAS A&M UNIVERSITY- VET. MED. TEACH. HOSP.

42. Business Mailing Address and Telephone Number Street or P.O. Box: UNIVERSITY DR. BLDG. 508 Telephone: (979) 845-9107

City: COLLEGE STATION State: TX Zip Code: 77843-4457

43. Business Location (if different from mailing address) Number and Street

City State Zip Code

44. Federal Tax Identification Number: 74-6000-531

45. Primary North American Industry Classification System Code (6 digit): XXXX

46. Specific NAICS Code (6 digit): XXXX

47. Texas Comptroller Taxpayer No.: XXXX

48. Workers' Compensation Insurance Company: TAMU- RISK MANAGMENT & SAFETY

49. Policy Number: SELF INSURED

50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)

X Sherry Haddix - Business Assoc. II Date 2-23-07

TEXAS WORKERS' COMPENSATION COMMISSION

02/23/2007 15:23 9798456226 VMTH ADMIN PAGE 06/07

623

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, Unless the Division specifically requests a direct filing.

CLAIM #

CARRIER'S CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex F ☑ M ☐
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y) 05-21-83
6. Does the Employee Speak English? YES ☑ NO ☐ If No, Specify Language
7. Race White ☐ Black ☐ Asian ☐
8. Ethnicity Hispanic ☑ Native American ☐ Other ☐
9. Mailing Address Street or P.O. Box
City State Zip Code County
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☑ Divorced ☐
11. Number of Dependent Children: 0
12. Spouse's Name: N/A
13. Doctor's Name: N/A
14. Doctor's Mailing Address (Street or P.O.Box): N/A
City State Zip Code: N/A

15. Date of Injury (m-d-y): 7-4-7-12
16. Time of Injury: N/ : am ☐ pm ☐
17. Date Lost Time Began (m-d-y) NONE
18. Nature of Injury*: POTENTIAL EXPOSURE
19. Part of Body Injured or Exposed*: RESPIRATORY
20. How and Why Injury/Illness Occurred*: POTENTIAL EXPOSURE TO LABORATORY ISOLATE (COCCIDIOIDES)
21. Was employee doing his regular job? YES ☑ NO ☐
22. Worksite Location of Injury (stairs, dock, etc.)*: CLIN MICRO LAB, VMTH
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site: VMTH, CLIN MICRO LAB,ROOM 2015
Street or P.O.Box: COLLEGE OF VET. MEDICINE
County: BRAZOS
City: COLLEGE STATION State: TX Zip Code: 77843
24. Cause of Injury(fall, tool, machine, etc.)*: potential exposure to infectious agent
25. List Witnesses: NONE
26. Return to work date/or expected (m-d-y):
27. Did employee die? YES ☐ NO ☑
28. Supervisor's Name: ROSIE GONZALEZ
29. Date Reported (m-d-y): 07-21-06

30. Date of Hire (m-d-y): 09-26-05
31. Was employee hired or recruited in Texas? YES ☐ NO ☑
32. Length of Service in Current Position: Months 9 Years 0
33. Length of Service in Occupation: Months 9 Years 0
34. Employee Payroll Classification Code: 5055
35. Occupation of Injured Worker: TECHNICIAN I
36. Rate of Pay at this Job: $10.15 Hourly $____ Weekly
37. Full Work Week is: 40 Hours ____ Days
38. Last Paycheck was: $620.00 for 40 Hours or ____ Days
39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form: SHERRY HADDIX
41. Name of Business: COLLEGE OF VET. MEDICINE
42. Business Mailing Address and Telephone Number
Street or P.O. Box: UNIVERSITY DR., BLD. 508
Telephone: (979) 845-9107
City: COLLEGE STATION State: TX Zip Code: 77845
43. Business Location (if different from mailing address) Number and Street
City State Zip Code
44. Federal Tax Identification Number: 74-6000-531
45. Primary North American Industry Classification System Code: (6 digit) XXXX
46. Specific NAICS Code (6 digit) XXXX
47. Texas Comptroller Taxpayer No. XXXX
48. Workers' Compensation Insurance Company: TAMU-RISK MANAGEMENT & SAFETY
49. Policy Number: SELF INSURED
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date 7-25-06

DIVISION OF WORKERS' COMPENSATION

624

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex F ☐ M ☑
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y) 02 - 12 - 1985
6. Does the Employee Speak English? If No, Specify Language YES ☑ NO ☐
7. Race White ☑ Black ☐ Asian ☐
8. Ethnicity Hispanic ☐ Native American ☑ Other ☐
9. Mailing Address Street or P.O. Box
City State Zip Code County
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☑ Divorced ☐
11. Number of Dependent Children: 0
12. Spouse's Name
13. Doctor's Name
14. Doctor's Mailing Address (Street or P.O.Box)
City State Zip Code

15. Date of Injury (m-d-y): 07 - 04 - 12 2006
16. Time of Injury: : am ☑ pm ☐
17. Date Lost Time Began (m-d-y): N .L .T
18. Nature of Injury*: Potential Exposure
19. Part of Body Injured or Exposed*: Respiratory
20. How and Why Injury/Illness Occurred*: Potential exposure to laboratory isolate (Coccidioides)
21. Was employee doing his regular job? YES ☑ NO ☐
22. Worksite Location of Injury (stairs, dock, etc.)*: Clinical Microbiology Lab
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site: VMTH-Clinical Microbiology
Street or P.O. Box: UNIVERSITY DR. BLDG. 508
County: BRAZOS
City: COLLEGE STATION State: TX Zip Code: 77843-4457
24. Cause of Injury(fall, tool, machine, etc.)*: Potential exposure to laboratory isolate
25. List Witnesses
26. Return to work date/or expected (m-d-y):
27. Did employee die? YES ☐ NO ☑
28. Supervisor's Name: Rosie Gonzales
29. Date Reported (m-d-y): 7 21 2006

30. Date of Hire (m-d-y): 6 15 2006
31. Was employee hired or recruited in Texas? YES ☑ NO ☐
32. Length of Service in Current Position: Months 1 Years
33. Length of Service in Occupation: Months 1 Years
34. Employer Payroll Classification Code: 7561
35. Occupation of Injured Worker: Student Worker I
36. Rate of Pay at this Job: $6.50 Hourly $ Weekly
37. Full Work Week is: 30 Hours Days
38. Last Paycheck was: $293 for 53 Hours or Days
39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form: ALICE REVILLA
41. Name of Business: TEXAS A&M UNIVERSITY- VET. MED. TEACH. HOSP.
42. Business Mailing Address and Telephone Number
Street or P.O. Box: UNIVERSITY DR. BLDG. 508
Telephone: (979) 458-4600
City: COLLEGE STATION State: TX Zip Code: 77843-4457
43. Business Location (If different from mailing address) Number and Street
City State Zip Code
44. Federal Tax Identification Number: 74-6000-531
45. Primary North American Industry Classification System Code:(6 digit) xxxx
46. Specific NAICS Code (6 digit) xxxx
47. Texas Comptroller Taxpayer No. xxxx
48. Workers' Compensation Insurance Company: TAMU- RISK MANAGMENT & SAFETY
49. Policy Number: SELF INSURED
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING): X Alice Revilla BVD Assist II Date 7-25-06

625

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.) –

2. Sex F ☑ M ☐

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 08 -29 -1953

6. Does the Employee Speak English? If No, Specify Language
YES ☑ NO ☐

7. Race White ☑ Black ☐ Asian ☐

8. Ethnicity Hispanic ☑ Native American ☐ Other ☐

9. Mailing Address Street or P.O. Box

City | State | Zip Code | County

10. Marital Status Married ☐ Widowed ☐ Seperated ☐ Single ☑ Divorced ☐

11. Number of Dependent Children: 0

12. Spouse's Name

13. Doctor's Name: Dr.Kimberely Wegner

14. Doctor's Mailing Address (Street or P.O.Box): Scott and White

City: College Station | State: TX | Zip Code: 77840

15. Date of Injury (m-d-y): 07 -04-12 2006

16. Time of Injury : am ☐ pm ☐

17. Date Lost Time Began (m-d-y) N -L -T

18. Nature of Injury*: Potential Exposure

19. Part of Body Injured or Exposed*: Respiratory

20. How and Why Injury/Illness Occurred*: Potential exposure to laboratory isolate (Coccidiolides)

21. Was employee doing his regular job? YES ☑ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)*: Clincal Microbiology Lab

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site
VMTH-Clinical Microbiology
Street or P.O. Box: UNIVERSITY DR. BLDG. 508 | County: BRAZOS
City: COLLEGE STATION | State: TX | Zip Code: 77843-4457

24. Cause of Injury(fall, tool, machine, etc.)*: Potential exposure to laboratory Isolate

25. List Witnesses: Mellissa C. Libal

26. Return to work date/or expected (m-d-y)

27. Did employee die? YES ☐ NO ☑

28. Supervisor's Name: Mellissa Libal

29. Date Reported (m-d-y) 7 -21 -2006

30. Date of Hire (m-d-y): 2 -20 -1992

31. Was employee hired or recruited in Texas? YES ☑ NO ☐

32. Length of Service in Current Position: Months ____ Years 14

33. Length of Service in Occupation: Months ____ Years 14

34. Employee Payroll Classification Code: 9241

35. Occupation of Injured Worker: Tech I lab coordinator

36. Rate of Pay at this Job: $18.6 Hourly $ ____ Weekly

37. Full Work Week is: 80 Hours ____ Days

38. Last Paycheck was: $2942. for ____ Hours or 21 Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form: ALICE REVILLA

41. Name of Business: TEXAS A&M UNIVERSITY- VET. MED. TEACH. HOSP.

42. Business Mailing Address and Telephone Number
Street or P.O. Box: UNIVERSITY DR. BLDG. 508 | Telephone: (979) 458-4500
City: COLLEGE STATION | State: TX | Zip Code: 77843-4457

43. Business Location (if different from mailing address) Number and Street
City | State | Zip Code

44. Federal Tax Identification Number: 74-6000-531

45. Primary North American Industry Classification System Code: (6 digit) xxxx

46. Specific NAICS Code (6 digit) xxxx

47. Texas Comptroller Taxpayer No. xxxx

48. Workers' Compensation Insurance Company: TAMU- RISK MANAGMENT & SAFETY

49. Policy Number: SELF INSURED

50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Alice Revilla Date 7/25/06

626

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, Unless the Division specifically requests a direct filing.

CLAIM #

CARRIER'S CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☑ M ☐

3. Social Security Number | 4. Home Phone | 5. Date of Birth (m-d-y): 11-09-48

6. Does the Employee Speak English? If No, Specify Language: YES ☑ NO ☐

7. Race: White ☑ Black ☐ Asian ☐

8. Ethnicity: Hispanic ☐ Native American ☐ Other ☑

9. Mailing Address Street or P.O. Box

City | State | Zip Code | County

10. Marital Status: Married ☑ Widowed ☐ Separated ☐ Single ☐ Divorced ☐

11. Number of Dependent Children: 0

12. Spouse's Name: GEORGE

13. Doctor's Name: DR. MANUEL JOSE

14. Doctor's Mailing Address (Street or P.O.Box): SCOTT & WHITE CLINIC

City: COLLEGE STATION State: TX Zip Code: 77845

15. Date of Injury (m-d-y): 7-4-7-12

16. Time of Injury: N/ : am ☐ pm ☐

17. Date Last Time Began (m-d-y): N NONE

18. Nature of Injury*: POTENTIAL EXPOSURE

19. Part of Body Injured or Exposed*: N/A

20. How and Why Injury/Illness Occurred*: POTENTIAL EXPOSURE TO LABORATORY ISOLATE (COCCIDIOIDES)

21. Was employee doing his regular job? YES ☑ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)*: CLIN MICRO LAB, VMTH

23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site: VMTH, CLIN MICRO LAB,ROOM 2015

Street or P.O.Box: COLLEGE OF VET. MEDICINE County: BRAZOS

City: COLLEGE STATION State: TX Zip Code: 77843

24. Cause of Injury(fall, tool, machine, etc.)*: potential exposure to infectious agent

25. List Witnesses: NONE

26. Return to work date/or expected (m-d-y): - -

27. Did employee die? YES ☐ NO ☑

28. Supervisor's Name: DR. GERALD BRATTON

29. Date Reported (m-d-y): 07-21-06

30. Date of Hire (m-d-y): 07-01-98

31. Was employee hired or recruited in Texas? YES ☑ NO ☐

32. Length of Service in Current Position: Months 21 Years

33. Length of Service in Occupation: Months Years 29

34. Employee Payroll Classification Code: 7664

35. Occupation of Injured Worker: VETERINARIAN

36. Rate of Pay at this Job: $8083.33 Hourly $ Weekly

37. Full Work Week is: 40 Hours Days

38. Last Paycheck was: $8083.33 for Hours or Days

39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form: SHERRY HADDIX

41. Name of Business: COLLEGE OF VET. MEDICINE

42. Business Mailing Address and Telephone Number
Street or P.O. Box: UNIVERSITY DR., BLD. 508 Telephone: (979) 845-9107

City: COLLEGE STATION State: TX Zip Code: 77845

43. Business Location (if different from mailing address) Number and Street

City State Zip Code

44. Federal Tax Identification Number: 74-6000-531

45. Primary North American Industry Classification System Code:(6 digit) XXXX

46. Specific NAICS Code (6 digit) XXXX

47. Texas Comptroller Taxpayer No. XXXX

48. Workers' Compensation Insurance Company: TAMU-RISK MANAGEMENT & SAFETY

49. Policy Number: SELF INSURED

50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)

X Sherry Haddix Date 7-25-06

DIVISION OF WORKERS' COMPENSATION

627

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)	2. Sex F ☐ M ☑	15. Date of Injury (m-d-y) 07 04-12 2006	16. Time of Injury : am ☐ pm ☐
3. Social Security Number	4. Home Phone	5. Date of Birth (m-d-y) 10 -22 - 82	17. Date Lost Time Began (m-d-y) N -L -T
6. Does the Employee Speak English? YES ☑ NO ☐ If No, Specify Language		18. Nature of Injury* Potential Exposure	19. Part of Body Injured or Exposed* Respiratory
7. Race White ☑ Black ☐ Asian ☐	8. Ethnicity Hispanic ☑ Native American ☐ Other ☐	20. How and Why Injury/Illness Occurred* Potential exposure to laboratory isolate (Coccidioides)	
9. Mailing Address Street or P.O. Box		21. Was employee doing his regular job? YES ☑ NO ☐	22. Worksite Location of Injury (stairs, dock, etc.)* Clincal Microbiology Lab
City State Zip Code County		23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site VMTH-Clinical Microbiology Street or P.O. Box UNIVERSITY DR. BLDG. 508 County BRAZOS	
10. Marital Status Married ☐ Widowed ☐ Separated ☐ Single ☑ Divorced ☐		City COLLEGE STATION State TX Zip Code 77843-4457	
11. Number of Dependent Children 0	12. Spouse's Name	24. Cause of Injury(fall, tool, machine, etc.)* Potential exposure to laboratory isolate	
13. Doctor's Name		25. List Witnesses Mellissa C. Libal and Rosie Gonzales	
14. Doctor's Mailing Address (Street or P.O.Box)		26. Return to work date/or expected (m-d-y)	27. Did employee die? YES ☐ NO ☑
City State Zip Code		28. Supervisor's Name Rosie Gonzales	29. Date Reported (m-d-y) 7 21 2006

30. Date of Hire (m-d-y) 03 20 2006	31. Was employee hired or recruited in Texas? YES ☑ NO ☐	32. Length of Service in Current Position Months 2 Years	33. Length of Service in Occupation Months 2 Years
34. Employee Payroll Classification Code 5005	35. Occupation of Injured Worker Tech I		
36. Rate of Pay at this Job $10.15 Hourly $ Weekly	37. Full Work Week is: 80 Hours Days	38. Last Paycheck was: $627 for 80 Hours or Days	39. Is employee an Owner, Partner, or Corporate Officer? YES ☐ NO ☑

40. Name and Title of Person Completing Form ALICE REVILLA		41. Name of Business TEXAS A&M UNIVERSITY- VET. MED. TEACH. HOSP.	
42. Business Mailing Address and Telephone Number Street or P.O. Box UNIVERSITY DR. BLDG. 508 Telephone (979) 458-4500		43. Business Location (if different from mailing address) Number and Street	
City COLLEGE STATION State TX Zip Code 77843-4457		City State Zip Code	
44. Federal Tax Identification Number 74-6000-531	45. Primary North American Industry Classification System Code: (6 digit) XXXX	46. Specific NAICS Code (6 digit) XXXX	47. Texas Comptroller Taxpayer No. XXXX
48. Workers' Compensation Insurance Company TAMU- RISK MANAGMENT & SAFETY		49. Policy Number SELF INSURED	

50. Did you request accident prevention services in past 12 months? YES ☐ NO ☑ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING) X Alice Revilla Lab Assoc II Date 7.25.06

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last First. M.I.)

2. Sex ☐ F ☒ M

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 9-12-73

6. Does the Employee Speak English? If No, Specify Language
☒ YES ☐ NO

7. Race ☐ White ☐ Black ☐ Asian

8. Ethnicity ☒ Hispanic ☐ Native American ☐ Other

9. Mailing Address
Street or P.O. Box

City State ZIP Code County

10. Marital Status
☒ Married ☐ Widowed ☐ Separted ☐ Single ☐ Divorced

11. Number of Dependent Children

12. Spouse's Name

13. Doctor's Name (seen for this injury)

14. Doctor's Mailing Address (Street or P.O. Box)

City State ZIP Code

15. Date of Injury (m-d-y) 7-29-02

16. Time of Injury 10:00 ☒ am ☐ pm

17. Date Lost Time Began (m-d-y) NLT

18. Nature of Injury* EXPOSURE

19. Part of Body Injured or Exposed* SYSTEM

20. How and Why Injury/Illness Occurred*
POSSIBLE EXPOSURE TO FRANCISELLA TULARENSIS (BIO-HAZARDOUS AGENT)

21. Was Employee doing his regular job? ☒ YES ☐ NO

22. Worksite Location of Injury (stairs, dock, etc.)* LAB

23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site TVMDL
Street or P.O. Box MS 4477 County Brazos
City College Station State TX ZIP Code 77843

24. Cause of Injury (fall, tool, machine, etc.)*
EXPOSURE

25. List Witnesses
DR LIBAL; MELISSA PECHAL; HOLLI TEITJEN

26. Return to work: ☐ Date ☐ Expected

27. Did Employee die? ☐ YES ☒ NO

28. Supervisor's Name DR LIBAL

29. Date Reported (m-d-y) 7-31-02

30. Date of Hire (m-d-y) 12-28-95

31. Was employee hired or recruited in Texas? ☒ YES ☐ NO

32. Length of Service in Current Position Months ____ Years 7

33. Length of Service in Occupation Months ____ Years 7

34. Employee Payroll Classification Code/Title Code 5005

35. Occupation of Injured Worker TECHNICIAN I

36. Rate of Pay at this Job $ 10.74 Hourly $ 429.60 Weekly

37. Full Work Week is: 40 Hours 5 Days

38. Last Paycheck was: $ 859.20 for 80 Hours or ____ Days

39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form
KEVIN KARLI

41. Name of Business
TAMU - TVMDL

42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone 979-862-4028
City College Station State TX ZIP Code 77843-1255

43. Business location (if different from mailing address)
Number and Street
City COLLEGE State TX ZIP Code 77843

44. Federal Tax Identification Number ☒ N/A

45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A

46. Specific SIC Code * (4 digit) ☒ N/A

47. Texas Comptroller Taxpayer No. ☒ N/A

48. Workers' Compensation Insurance Company
The Texas A&M University System

49. Policy Number
Self-Insured

50. Did you request accident prevention services in past 12 months? ☐ N/A
☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 8/5/2002
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

KEVIN KARLI HR PROGRAM ASSISTANT

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex ☒ F ☐ M

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 2-5-80

6. Does the Employee Speak English? If No, Specify Language ☒ YES ☐ NO

7. Race ☒ White ☐ Black ☐ Asian

8. Ethnicity ☐ Hispanic ☐ Native American ☐ Other

9. Mailing Address
Street or P.O. Box

City State ZIP Code County

10. Marital Status ☐ Married ☐ Widowed ☐ Separted ☒ Single ☐ Divorced

11. Number of Dependent Children

12. Spouse's Name

13. Doctor's Name (seen for this injury)

14. Doctor's Mailing Address (Street or P.O. Box)

City State ZIP Code

15. Date of Injury (m-d-y) 7-25-02

16. Time of Injury 14:00 ☐ am ☒ pm

17. Date Lost Time Began (m-d-y) NLT

18. Nature of Injury* EXPOSURE

19. Part of Body Injured or Exposed* SYSTEM

20. How and Why Injury/Illness Occurred*
POSSIBLE EXPOSURE TO FRANCISELLA TULARENSIS (BIO HAZARDOUS AGENT)

21. Was Employee doing his regular job? ☒ YES ☐ NO

22. Worksite Location of Injury (stairs, dock, etc.)* LAB

23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site TVMDL
Street or P.O. Box MS 4477 County Brazos
City College Station State TX ZIP Code 77843

24. Cause of Injury (fall, tool, machine, etc.)* EXPOSURE

25. List Witnesses
JORGE MEDINA; MELISSA PECHAL; DR LIBAL

26. Return to work: ☐ Date ☐ Expected

27. Did Employee die? ☐ YES ☒ NO

28. Supervisor's Name DR LIBAL

29. Date Reported (m-d-y) 7-31-02

30. Date of Hire (m-d-y) 10-20-99

31. Was employee hired or recruited in Texas? ☒ YES ☐ NO

32. Length of Service in Current Position Months 6 Years 2

33. Length of Service in Occupation Months 6 Years 2

34. Employee Payroll Classification Code/Title Code 7561

35. Occupation of Injured Worker STUDENT WORKER

36. Rate of Pay at this Job $ 6.00 Hourly $ 123.00 Weekly

37. Full Work Week is: 20 Hours _____ Days

38. Last Paycheck was: $ 246.00 for 41 Hours or _____ Days

39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form
KEVIN KARLI

41. Name of Business
TAMU - TVMDL

42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone 979-862-4028
City College Station State TX ZIP Code 77843-1255

43. Business location (if different from mailing address)
Number and Street
City COLLEGE State TX ZIP Code 77843

44. Federal Tax Identification Number ☒ N/A

45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A

46. Specific SIC Code * (4 digit) ☒ N/A

47. Texas Comptroller Taxpayer No. ☒ N/A

48. Workers' Compensation Insurance Company
The Texas A&M University System

49. Policy Number
Self-Insured

50. Did you request accident prevention services in past 12 months? ☐ N/A
☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 8/5/2002
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

KEVIN KARLI HR PROGRAM ASSISTANT

Name	Date	Injury	Method of Contamination/Possible Contaminate	Department
	10/8/2002	Exposure	Punctured thumb w/scalpel during surgical procedure.	STHS
	10/25/2002	Exposure	Punctured her findger while washing a syringe	VTEA
	10/18/2002	Exposure	Anthrax positive tissues	TVMDL
	10/18/2002	Exposure	Anthrax positive tissues	TVMDL
	10/21/2002	Exposure	Anthrax positive tissues	TVMDL
	10/18/2002	Exposure	Anthrax positive tissues	TVMDL
a	10/22/2002	Exposure	Punctured with needle	PHPL
	10/4/2002	Exposure	Punctured with needle	Vmed
	11/14/2002	Exposure	Punctured with needle	HSCN
	11/19/2002	Exposure	Infected lab animals	HCSC
	11/11/2002	Exposure	Exposure to chemicals	BIOL
	11/26/2002	Exposure	Cut thumb changing IV bag	VTEA
	11/13/2002	Exposure	Handling a sharps container	BIOL
	1/24/2003	Exposure	Glass pipetter broke and cut finger	IBT
	2/27/2003	Exposure	Contact with blood	STHS
a	2/10/2003	Exposure	Punctured with needle	EHSD
ın	2/3/2003	Exposure	Contact w/person w/ tuberculosis	UPD
	2/3/2003	Exposure	Contact w/person w/ tuberculosis	UPD
	3/19/2003	Exposure	Exposed brucella melitensis	TVEA
	3/2/2003	Exposure	Possible exposure to tuberculosis	LARR
	5/15/2003	Exposure	Inhaled Fumes	PHPL
	5/8/2003	Exposure	Possible exposure to tuberculosis	PHPL
	5/5/2003	Exposure	Punctured with needle	TVMDL
	7/21/2004	Exposure	Cut while preforming a necropsy	Vet Path
er	10/24/2003	Exposure	Brucellosis	LA Surg
ı	10/24/2003	Exposure	Brucellosis	LA Surg
ı	9/18/2003	Cut	Pipet break	Nuc Eng
n	3/5/2001	Cut	Cut from contaminated blade	VLAM
ı	9/25/2000	Exposure	Punctured from needle /lab bacterium	Reynolds
	10/11/2000	Puncture	Handling a sharps container/electron microscopy lab	TVMDL
	8/27/2001	Exposure	Tuberculosis exposure	LAAR
	5/23/2001	Exposure	Systemic fungus	TVMDL
er	06/14/004	Puncture	Tube punctured finger/ blood sampling	SM Animal
	6/14/2002	Puncture	Punctured with needle	LARR
	12/11/2001	Puncture	Punctured with needle	VTEA
ne	11/13/2001	Puncture	Punctured with needle	VTEA
an	11/8/2001	Puncture	Punctured/ necropsy lab	TVMDL
	12/3/2001	Exposure	Q Fever	LARR
	1/28/2002	Exposure	Brucellosis	TVMDL
	8/28/2002	Exposure	Contaminated Needle/Serology Lab	TVMDL
ı	7/26/2002	Exposure	Franccisells Tularensis Exposure	TVMDL

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex ☒ F ☐ M

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 5-28-76

6. Does the Employee Speak English? If No, Specify Language ☒ YES ☐ NO

7. Race ☒ White ☐ Black ☐ Asian

8. Ethnicity ☐ Hispanic ☐ Native American ☐ Other

9. Mailing Address
Street or P.O. Box

City | State | ZIP Code | County

10. Marital Status ☐ Married ☐ Widowed ☐ Separted ☒ Single ☐ Divorced

11. Number of Dependent Children

12. Spouse's Name

13. Doctor's Name (seen for this injury)

14. Doctor's Mailing Address (Street or P.O. Box)

City | State | ZIP Code

15. Date of Injury (m-d-y) 7-26-02

16. Time of Injury 14:00 ☐ am ☒ pm

17. Date Lost Time Began (m-d-y) NLT

18. Nature of Injury* EXPOSURE

19. Part of Body Injured or Exposed* SYSTEM

20. How and Why Injury/Illness Occurred*
POSSIBLE EXPOSURE TO FRANCISELLA TULARENSIS (BIOHAZARDOUS AGENT)

21. Was Employee doing his regular job? ☒ YES ☐ NO

22. Worksite Location of Injury (stairs, dock, etc.)* LAB

23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site TVMDL
Street or P.O. Box MS 4477 County Brazos
City College Station State TX ZIP Code 77843

24. Cause of Injury (fall, tool, machine, etc.)* EXPOSURE

25. List Witnesses
JORGE MEDINA; HOLLI TEITJEN; & MELISSA LIBAL

26. Return to work: ☐ Date ☐ Expected

27. Did Employee die? ☐ YES ☒ NO

28. Supervisor's Name MELISSA LIBAL

29. Date Reported (m-d-y) 7-31-02

30. Date of Hire (m-d-y) 2-4-99

31. Was employee hired or recruited in Texas? ☒ YES ☐ NO

32. Length of Service in Current Position Months ____ Years 3

33. Length of Service in Occupation Months ____ Years 3

34. Employee Payroll Classification Code/Title Code 5005

35. Occupation of Injured Worker TECHNICIAN 1

36. Rate of Pay at this Job $ 10.45 Hourly $ 418.00 Weekly

37. Full Work Week is: 40 Hours 5 Days

38. Last Paycheck was: $ 836.00 for 80 Hours or ____ Days

39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form
KEVIN KARLI

41. Name of Business
TAMU - TVMDL

42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone 979-862-4028
City College Station State TX ZIP Code 77843-1255

43. Business location (if different from mailing address)
Number and Street
City COLLEGE State TX ZIP Code 77843

44. Federal Tax Identification Number ☒ N/A

45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A

46. Specific SIC Code * (4 digit) ☒ N/A

47. Texas Comptroller Taxpayer No. ☒ N/A

48. Workers' Compensation Insurance Company
The Texas A&M University System

49. Policy Number
Self-Insured

50. Did you request accident prevention services in past 12 months? ☐ N/A
☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 8/5/2002
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

KEVIN KARLI HR PROGRAM ASSISTANT

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex ☐ F ☐ M

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 3-18-79

6. Does the Employee Speak English? If No, Specify Language ☐ YES ☐ NO

7. Race ☐ White ☐ Black ☐ Asian

8. Ethnicity ☐ Hispanic ☐ Native American ☐ Other

9. Mailing Address
Street or P.O. Box

City State ZIP Code County

10. Marital Status ☐ Married ☐ Widowed ☐ Separted ☐ Single ☐ Divorced

11. Number of Dependent Children

12. Spouse's Name

13. Doctor's Name (seen for this injury)

14. Doctor's Mailing Address (Street or P.O. Box)

City State ZIP Code

15. Date of Injury (m-d-y) 8-28-02

16. Time of Injury 14:00 ☐ am ☐ pm

17. Date Lost Time Began (m-d-y) NLT

18. Nature of Injury* EXPOSURE

19. Part of Body Injured or Exposed* FINGER

20. How and Why Injury/Illness Occurred*
EMPLOYEE PUNCTURED HER FINGER WITH A BLOOD CONTAMINATED NEEDLE

21. Was Employee doing his regular job? ☐ YES ☐ NO

22. Worksite Location of Injury (stairs, dock, etc.)* SEROLOGY LAB

23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site TVMDL
Street or P.O. Box MS 4471 County Brazos
City College Station State TX ZIP Code 77843

24. Cause of Injury (fall, tool, machine, etc.)* EXPOSURE

25. List Witnesses
KATHY NEIMAN

26. Return to work: ☐ Date ☐ Expected

27. Did Employee die? ☐ YES ☐ NO

28. Supervisor's Name AB ANGULO

29. Date Reported (m-d-y) 8-28-02

30. Date of Hire (m-d-y) 8-23-00

31. Was employee hired or recruited in Texas? ☐ YES ☐ NO

32. Length of Service in Current Position Months ____ Years 2

33. Length of Service in Occupation Months ____ Years 2

34. Employee Payroll Classification Code/Title Code 5007

35. Occupation of Injured Worker LAB SUPERVISOR

36. Rate of Pay at this Job $ 11.55 Hourly $ 462.60 Weekly

37. Full Work Week is: 40 Hours 5 Days

38. Last Paycheck was: $ 2009.00 for ____ Hours or ____ Days

39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☐ NO

40. Name and Title of Person completing form
KEVIN KARLI

41. Name of Business
TAMU-TVMDL

42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone 979-862-4028
City College Station State TX ZIP Code 77843-1255

43. Business location (if different from mailing address)
Number and Street
City COLLEGE State TX ZIP Code 77843

44. Federal Tax Identification Number ☐ N/A

45. Primary Standard Industrial Classification SIC Code * (4 digit) ☐ N/A

46. Specific SIC Code * (4 digit) ☐ N/A

47. Texas Comptroller Taxpayer No. ☐ N/A

48. Workers' Compensation Insurance Company
The Texas A&M University System

49. Policy Number
Self-Insured

50. Did you request accident prevention services in past 12 months? ☐ N/A ☐ YES ☐ NO
If yes, did you receive them? ☐ YES ☐ NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 8/28/2002
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

KEVIN KARLI HR PROGRAM ASSISTANT

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex ☐ F ☐ M

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 2-17-77

6. Does the Employee Speak English? If No, Specify Language ☐ YES ☐ NO

7. Race ☐ White ☐ Black ☐ Asian

8. Ethnicity ☐ Hispanic ☐ Native American ☐ Other

9. Mailing Address
Street or P.O. Box

City State ZIP Code County

10. Marital Status ☐ Married ☐ Widowed ☐ Separted ☐ Single ☐ Divorced

11. Number of Dependent Children

12. Spouse's Name

13. Doctor's Name (seen for this injury)

14. Doctor's Mailing Address (Street or P.O. Box)

City State ZIP Code

15. Date of Injury (m-d-y) 1-28-02

16. Time of Injury 09:00 ☐ am ☐ pm

17. Date Lost Time Began (m-d-y) NLT

18. Nature of Injury* EXPOSURE

19. Part of Body Injured or Exposed* SYSTEM

20. How and Why Injury/Illness Occurred*
ALLEGED EXPOSURE TO BRUCELLOSIS

21. Was Employee doing his regular job? ☐ YES ☐ NO

22. Worksite Location of Injury (stairs, dock, etc.)* LAB

23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site TVMDL
Street or P.O. Box MS 4471 County Brazos
City College Station State TX ZIP Code 77843

24. Cause of Injury (fall, tool, machine, etc.)* EXPOSURE

25. List Witnesses
MELISSA PECHAL

26. Return to work: ☐ Date ☐ Expected

27. Did Employee die? ☐ YES ☐ NO

28. Supervisor's Name SONIA

29. Date Reported (m-d-y) 8-23-02

30. Date of Hire (m-d-y) 7-18-01

31. Was employee hired or recruited in Texas? ☐ YES ☐ NO

32. Length of Service in Current Position Months _____ Years 1

33. Length of Service in Occupation Months _____ Years 1

34. Employee Payroll Classification Code/Title Code 5005

35. Occupation of Injured Worker STUDENT WORKER - WAGE

36. Rate of Pay at this Job $ 9.49 Hourly $ 265.72 Weekly

37. Full Work Week is: 20 Hours 5 Days

38. Last Paycheck was: $ 531.44 for 56 Hours or _____ Days

39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☐ NO

40. Name and Title of Person completing form
KEVIN KARLI

41. Name of Business
TAMU-TVMDL

42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone 979-862-4028
City College Station State TX ZIP Code 77843-1255

43. Business location (if different from mailing address)
Number and Street
City COLLEGE State TX ZIP Code 77843

44. Federal Tax Identification Number ☐ N/A

45. Primary Standard Industrial Classification SIC Code * (4 digit) ☐ N/A

46. Specific SIC Code * (4 digit) ☐ N/A

47. Texas Comptroller Taxpayer No. ☐ N/A

48. Workers' Compensation Insurance Company
The Texas A&M University System

49. Policy Number
Self-Insured

50. Did you request accident prevention services in past 12 months? ☐ N/A
☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 8/23/2002
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

KEVIN KARLI HR PROGRAM ASSISTANT

TX 83 TX 90

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex ☒ F ☐ M
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y) 12/03/65
6. Does the Employee Speak English? If No, Specify Language ☒ YES ☐ NO
7. Race ☒ White ☐ Black ☐ Asian
8. Ethnicity ☐ Hispanic ☐ Native American ☐ Other
9. Mailing Address Street or P.O. Box
City State ZIP Code County
10. Marital Status ☒ Married ☐ Widowed ☐ Separted ☐ Single ☐ Divorced
11. Number of Dependent Children 0
12. Spouse's Name
13. Doctor's Name (seen for this injury) Dr. Ngo
14. Doctor's Mailing Address (Street or P.O. Box) 1600 University Dr. E
City College Station State TX ZIP Code 77840

15. Date of Injury (m-d-y) 6/20/01
16. Time of Injury 3:00 ☐ am ☒ pm
17. Date Lost Time Began (m-d-y) n/a
18. Nature of Injury* Exposure
19. Part of Body Injured or Exposed* System
20. How and Why Injury/Illness Occurred* Exposure to Q fever.
21. Was Employee doing his regular job? ☒ YES ☐ NO
22. Worksite Location of Injury (stairs, dock, etc.)* BL 3 area
23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site LARR Building
Street or P.O. Box County Brazos
City College Station State TX ZIP Code 77843
24. Cause of Injury (fall, tool, machine, etc.)* Diseased sheep
25. List Witnesses none
26. Return to work: ☐ Date ☐ Expected
27. Did Employee die? ☐ YES ☒ NO
28. Supervisor's Name David Carlton
29. Date Reported (m-d-y) 6/20/01

30. Date of Hire (m-d-y) 11/05/91
31. Was employee hired or recruited in Texas? ☒ YES ☐ NO
32. Length of Service in Current Position Months 9 Years 0
33. Length of Service in Occupation Months 10 Years 9
34. Employee Payroll Classification Code/Title Code 5068
35. Occupation of Injured Worker Lab Animal Tech II
36. Rate of Pay at this Job $ 10.11 Hourly $ 404.40 Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $ 808.80 for 80 Hours or Days
39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form Mary R. Smith SR HR Technician
41. Name of Business LAAR
42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone (409) 862-1720
City College Station State TX ZIP Code 77843-1255
43. Business location (if different from mailing address)
Number and Street MS 4473
City College Station State TX ZIP Code 77843-4473
44. Federal Tax Identification Number ☒ N/A
45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A
46. Specific SIC Code * (4 digit) ☒ N/A
47. Texas Comptroller Taxpayer No. ☒ N/A
48. Workers' Compensation Insurance Company The Texas A&M University System
49. Policy Number Self-Insured
50. Did you request accident prevention services in past 12 months? ☒ N/A ☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X
Authorized Signature of Supervisor
10/3/2001

TWCC-1 (2-91)
2/13/91

Rule 120.2

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex ☐ F ☐ M
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y) 9/12/73
6. Does the Employee Speak English? If No, Specify Language ☒ YES ☐ NO
7. Race ☒ White ☐ Black ☐ Asian
8. Ethnicity ☒ Hispanic ☐ Native American ☐ Other
9. Mailing Address Street or P.O. Box
City State ZIP Code County
10. Marital Status ☒ Married ☐ Widowed ☐ Separted ☐ Single ☐ Divorced
11. Number of Dependent Children 0
12. Spouse's Name
13. Doctor's Name (seen for this injury) Dr. Wegener
14. Doctor's Mailing Address (Street or P.O. Box) 1600 University Dr. E.
City College Station State TX ZIP Code 77840

15. Date of Injury (m-d-y) 5/23/01
16. Time of Injury 11:00 ☒ am ☐ pm
17. Date Lost Time Began (m-d-y) n/a
18. Nature of Injury* Exposure
19. Part of Body Injured or Exposed* whoke body
20. How and Why Injury/Illness Occurred* Exposed to systemic fungus, not immediately known to be systemic fungus.
21. Was Employee doing his regular job? ☒ YES ☐ NO
22. Worksite Location of Injury (stairs, dock, etc.)* lab
23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site TVMDL
Street or P.O. Box 1 Sippel Rd. County Brazos
City College Station State TX ZIP Code 77843
24. Cause of Injury (fall, tool, machine, etc.)* exposure
25. List Witnesses none
26. Return to work: ☐ Date ☐ Expected
27. Did Employee die? ☐ YES ☒ NO
28. Supervisor's Name Dr. Melissa Libal
29. Date Reported (m-d-y) 6/11/01

30. Date of Hire (m-d-y) 12/28/95
31. Was employee hired or recruited in Texas? ☒ YES ☐ NO
32. Length of Service in Current Position Months 2 Years 9
33. Length of Service in Occupation Months 2 Years 9
34. Employee Payroll Classification Code/Title Code 5005
35. Occupation of Injured Worker Lab Technician
36. Rate of Pay at this Job $ 9.92 Hourly $ 396.80 Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $ 793.60 for 80 Hours or Days
39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form Mary R. Smith SR HR Technician
41. Name of Business TVMDL
42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone (409) 862-1720
City College Station State TX ZIP Code 77843-1255
43. Business location (if different from mailing address)
Number and Street 1 Sippel Rd
City College Station State TX ZIP Code 77843
44. Federal Tax Identification Number ☒ N/A
45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A
46. Specific SIC Code * (4 digit) ☒ N/A
47. Texas Comptroller Taxpayer No. ☒ N/A
48. Workers' Compensation Insurance Company The Texas A&M University System
49. Policy Number Self-Insured
50. Did you request accident prevention services in past 12 months? ☒ N/A ☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Authorized Signature of Supervisor 6/11/2001

TWCC-1 (2-91)
2/13/91

Rule 120.2

Tx 82 Tx 91

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM #

CARRIER'S CLAIM #

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex ☒ F ☐ M
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y) 12/03/65
6. Does the Employee Speak English? If No, Specify Language ☒ YES ☐ NO
7. Race ☒ White ☐ Black ☐ Asian
8. Ethnicity ☐ Hispanic ☐ Native American ☐ Other
9. Mailing Address Street or P.O. Box
City State ZIP Code County
10. Marital Status ☒ Married ☐ Widowed ☐ Separted ☐ Single ☐ Divorced
11. Number of Dependent Children 0
12. Spouse's Name
13. Doctor's Name (seen for this injury) Dr. Ngo
14. Doctor's Mailing Address (Street or P.O. Box) 1600 University Dr. E.
City College Station State TX ZIP Code 77840

15. Date of Injury (m-d-y) 8/27/01
16. Time of Injury 3:05 ☐ am ☒ pm
17. Date Lost Time Began (m-d-y) n/a
18. Nature of Injury* Exposure
19. Part of Body Injured or Exposed* Respiratory System
20. How and Why Injury/Illness Occurred* Employee was exposed to TB when a mechanical failure caused her HEPA air pack to shut down
21. Was Employee doing his regular job? ☒ YES ☐ NO
22. Worksite Location of Injury (stairs, dock, etc.)* Biohazard autoclave room
23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site LAAR
Street or P.O. Box County Brazos
City College Station State TX ZIP Code 77843
24. Cause of Injury (fall, tool, machine, etc.)* mechanical failure
25. List Witnesses Stacy Gillenwater, Laura Quinlan
26. Return to work: ☐ Date ☐ Expected
27. Did Employee die? ☐ YES ☒ NO
28. Supervisor's Name Steven Sterle
29. Date Reported (m-d-y) 8/27/01

30. Date of Hire (m-d-y) 11/05/91
31. Was employee hired or recruited in Texas? ☒ YES ☐ NO
32. Length of Service in Current Position Months 10 Years 9
33. Length of Service in Occupation Months 10 Years 9
34. Employee Payroll Classification Code/Title Code 5068
35. Occupation of Injured Worker Lab Animal Tech III
36. Rate of Pay at this Job $ 9.53 Hourly $ 381.20 Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $ 762.40 for 80 Hours or ____ Days
39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form Mary R. Smith SR HR Technician
41. Name of Business LAAR
42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone (409) 862-1720
City College Station State TX ZIP Code 77843-1255
43. Business location (if different from mailing address)
Number and Street MS 1250
City College Station State TX ZIP Code 77843-1250
44. Federal Tax Identification Number ☒ N/A
45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A
46. Specific SIC Code * (4 digit) ☒ N/A
47. Texas Comptroller Taxpayer No. ☒ N/A
48. Workers' Compensation Insurance Company The Texas A&M University System
49. Policy Number Self-Insured
50. Did you request accident prevention services in past 12 months? ☒ N/A ☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 8/29/2001
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

TEXAS WORKERS' COMPENSATION COMMISSION
Central Office, 4000 IH-35, Southfield Building
Austin, Texas 78704-7491

Send the specified copies to your Worker's Compensation carrier and the injured employee. Please read instruction sheet CAREFULLY, giving special attention to items marked with an asterisk (*).

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex ☒ F ☐ M
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y) 6/28/76
6. Does the Employee Speak English? If No, Specify Language ☒ YES ☐ NO
7. Race ☒ White ☐ Black ☐ Asian
8. Ethnicity ☐ Hispanic ☐ Native American ☐ Other
9. Mailing Address Street or P.O. Box
City State ZIP Code County
10. Marital Status ☒ Married ☐ Widowed ☐ Separted ☐ Single ☐ Divorced
11. Number of Dependent Children 0
12. Spouse's Name
13. Doctor's Name (seen for this injury) Wade Richardson
14. Doctor's Mailing Address (Street or P.O. Box) 1600 University Dr. E
City College Station State TX ZIP Code 77840

15. Date of Injury (m-d-y) 9/25/00
16. Time of Injury 4:40 ☐ am ☒ pm
17. Date Lost Time Began (m-d-y) n/a
18. Nature of Injury* contaminated needlestick
19. Part of Body Injured or Exposed* left index finger
20. How and Why Injury/Illness Occurred* Uncapping infected needle to dispose of needle properly. Needle contaminated with lab bacterium.
21. Was Employee doing his regular job? ☒ YES ☐ NO
22. Worksite Location of Injury (stairs, dock, etc.)* lab
23. Address Where Injury or Exposure Occurred
Name of business if incident occurred on a business site Reynolds Medical Bldg.
Street or P.O. Box County Brazos
City College Station State TX ZIP Code 77843
24. Cause of Injury (fall, tool, machine, etc.)* needlestick
25. List Witnesses none
26. Return to work: ☐ Date ☐ Expected
27. Did Employee die? ☐ YES ☒ NO
28. Supervisor's Name Jon Skare
29. Date Reported (m-d-y) 9/25/00

30. Date of Hire (m-d-y) 8/13/98
31. Was employee hired or recruited in Texas? ☒ YES ☐ NO
32. Length of Service in Current Position Months 1 Years 2
33. Length of Service in Occupation Months 1 Years 2
34. Employee Payroll Classification Code/Title Code 9221
35. Occupation of Injured Worker Graduate Research Assistant
36. Rate of Pay at this Job $ _____ Hourly $ _____ Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $ 1466.67 for 1 mo Hours or _____ Days
39. Is employees an Owner, Partner, or Corporate Officer? ☐ YES ☒ NO

40. Name and Title of Person completing form Mary R. Smith SR HR Technician
41. Name of Business MMIM
42. Business Mailing Address and Telephone Number
Street or PO Box MS 1255 Telephone (409) 862-1720
City College Station State TX ZIP Code 77843-1255
43. Business location (if different from mailing address)
Number and Street MS 1114
City College Station State TX ZIP Code 77843-1114
44. Federal Tax Identification Number ☒ N/A
45. Primary Standard Industrial Classification SIC Code * (4 digit) ☒ N/A
46. Specific SIC Code * (4 digit) ☒ N/A
47. Texas Comptroller Taxpayer No. ☒ N/A
48. Workers' Compensation Insurance Company The Texas A&M University System
49. Policy Number Self-Insured
50. Did you request accident prevention services in past 12 months? ☒ N/A ☐ YES ☐ NO If yes, did you receive them? ☐ YES ☐ NO
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ 9/26/2000
Authorized Signature of Supervisor

TWCC-1 (2-91)
2/13/91

Rule 120.2

TEXAS A&M UNIVERSITY
First Report of Injury or Illness

If student or visitor, fax to the Environmental Health & Safety Department at 845-1348 within 24 hours of the injury/illness.
If employee, fax to the Human Resources Department at 847-8546 within 24 hours of the injury/illness.

[1] Employee ☐ - *Complete items #1 - #32* Student ☐ - *Complete Items #1 - #13 & #32* Visitor ☐ - *Complete Items #1 - #13 & #32*	[2] Date of injury/illness (M-D-Y) 10 / 24 / 03	[3] Time of injury/illness 11 : 00 ☒ AM ☐ PM

[4] Name (Last, First, M.I.): [5] SSN:

[6] Address: Home #: Work #:

[7] Will medical attention be required for this injury/illness? Yes ☒ No ☐

[8] Address or location where injury or exposure occurred:
Bldg # or Street: LG. ANIMAL SURG City: C.S. State: TX Zip: 77843 County: BRAZO

[9] Specific location where injury or exposure occurred *(e.g., stairs, dock, laboratory)*: FOOD ANIMAL WARD

[10] Nature of injury/illness: *(e.g., bruise, cut, sprain, occupational disease)*: BRUCELLOSIS EXPOSURE

[11] Body part involved *(e.g., left arm, right eye)*: NOSE, FACE

[12] Cause of injury/illness *(e.g., fall, tool, machine, chemical)*: FAULTY SYRINGE

[13] How and why did this injury/illness occur?
GIVING VACCINE, SYRINGE BROKE

If the injury or illness being reported involves an employee, including student employees, complete the remainder of this form. If the injury or illness being reported involves a student or visitor, skip to item #32.

[14] Date Hired: / /	[15] Job Title:	[16] Full Time ☐ Part Time ☐
[17] Spouse's Name:		[18] Number of dependent children:
[19] Does employee speak English? Yes ☐ No ☐ If No, specify language:		[20] Date lost time began, *more than one full shift* (M-D-Y) / /
[21] Length of service in *current* position: Months Years		[22] Dept:

[23] Doctor's name: Doctor's address:

Will employee miss more than one shift? Yes ☐ No ☐

Was employee doing his/her job? Yes ☐ No ☐ [24] Did employee die as a result of this illness/injury? Yes ☐ No ☐

Was the employee using a back belt at the time of the injury? Yes ☐ No ☐

List of witnesses:

Supervisor's Name & telephone #:	[30] Date injury/illness was reported: / /	[31] Expected or return to work date: / /

Supervisor's signature and title:

Title: Bus Asst I

I confirm that the information furnished is true and complete to the best of my knowledge. Date: 10/24/03

TEXAS A&M UNIVERSITY
First Report of Injury or Illness

If student or visitor, fax to the Environmental Health & Safety Department at 845-1348 within 24 hours of the injury/illne
If employee, fax to the Human Resources Department at 847-8546 within 24 hours of the injury/illness.

[1] Employee ☐ - *Complete items #1 - #32* Student ☐ - *Complete Items #1 - #13 & #32* Visitor ☐ - *Complete items #1 - #13 & #32*	[2] Date of injury/illness (M-D-Y) 10 12/1 03	[3] Time of injury/illness 11 : 00 ☒A ☐ P

[4] Name (Last, First, M.I.):

[5] SSN:

[6] Address:

Home #:( )

Work #:( )

[7] Will medical attention be required for this injury/illness? Yes ☒ No ☐

[8] Address or location where injury or exposure occurred:
Bldg # or Street: LARGE ANIMAL MED Bldg City: C S State: TX Zip: 77843 County: Brazos

[9] Specific location where injury or exposure occurred *(e.g., stairs, dock, laboratory)*: Food animal ward

[10] Nature of injury/illness: *(e.g., bruise, cut, sprain, occupational disease)*: EXPOSURE TO BRUCELLOSIS

[11] Body part involved *(e.g., left arm, right eye)*: Right hand

[12] Cause of injury/illness *(e.g., fall, tool, machine, chemical)*: ~~Bad~~ faulty Syringe

[13] How and why did this injury/illness occur?
Faulty Syringe

If the injury or illness being reported involves an employee, including student employees, complete the remainder of this form. If the injury or illness being reported involves a student or visitor, skip to item #32.

[14] Date Hired: / /	[15] Job Title:	[16] Full Time ☐ Part Time ☐
[17] Spouse's Name:		[18] Number of dependent children:
[19] Does employee speak English? Yes ☐ No ☐ If No, specify language:		[20] Date lost time began, *more than one full shift (M-D-Y)* / /
[21] Length of service in *current* position: Months Years		[22] Dept:

Doctor's name: Doctor's address:

Will employee miss more than one shift? Yes ☐ No ☐

Was employee doing his/her job? Yes ☐ No ☐ [25] Did employee die as a result of this illness/injury? Yes ☐ No ☐

Was the employee using a back belt at the time of the injury? Yes ☐ No ☐

List of witnesses:

Supervisor's Name & telephone #:	[30] Date injury/illness was reported: / /	[31] Expected or return to work date: / /

Supervisor's signature and title:

Title: Bus Assoc I

I confirm that the information furnished is true and complete to the best of my knowledge. Date: 10/24/03

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee
***Employers – Do not send this form to the**
Texas Workers' Compensation Commission,
unless the Commission specifically requests a direct filing.

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.) [redacted]
2. Sex: F ☒ M ☐
3. Social Security Number [redacted]
4. Home Phone [redacted]
5. Date of Birth (m-d-y): 03-19-1958
6. Does the Employee Speak English? If No, Specify Language: YES ☒ NO ☐
7. Race: White ☐ Black ☐ Asian ☐
8. Ethnicity: Hispanic ☒ Native American ☐ Other ☐
9. Mailing Address: Street or P.O. Box [redacted] City [redacted] State [redacted] Zip Code [redacted] County [redacted]
10. Marital Status: Married ☒ Widowed ☐ Separated ☐ Single ☐ Divorced ☐
11. Number of Dependent Children
12. Spouse's Name
13. Doctor's Name
14. Doctor's Mailing Address (Street or P.O. Box) City State TX Zip Code

15. Date of Injury (m-d-y): 5-8-03
16. Time of Injury: 13:00 am ☐ pm ☒
17. Date Lost Time Began (m-d-y): NLT
18. Nature of Injury*: EXPOSURE
19. Part of Body Injured or Exposed*: SYSTEM
20. How and Why Injury/Illness Occurred*: EMPLOYEE MAY HAVE BEEN EXPOSED TO TB
21. Was employee doing his regular job? YES ☒ NO ☐
22. Worksite Location of Injury (stairs, dock. etc.)*: 3RD FL ANNEX ACQ
23. Address Where Injury or Exposure Occurred
Name of Business if incident occurred on a business site: PHPL
Street or P.O. Box: MS 1371 County: BZ
City: COLLEGE STATION State: TX Zip Code: 77843
24. Cause of injury (fall, tool, machine, etc.)*: EXPOSURE
25. List Witnesses: NONE
26. Return to work date/or expected (m-d-y)
27. Did employee die? YES ☐ NO ☒
28. Supervisor's Name: RUDY GRIMALDO
29. Date Reported (m-d-y): 05-08-2003

30. Date of Hire (m-d-y): 05-20-2002
31. Was employee hired or recruited in Texas? YES ☒ NO ☐
32. Length of Service in Current Position: Months ____ Years 1
33. Length of Service in Occupation: Months ____ Years 1
34. Employee Payroll Classification Code: 4002
35. Occupation of Injured Worker: CW 1
36. Rate of Pay at this Job: $ 6.94 Hourly $ 277.60 Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $ 555.20 For 80.00 Hours or ____ Days
39. Is employee an Owner, Partner, or Corporate Officer? Yes ☐ No ☒

40. Name and Title of Person Completing Form: KEVIN KARLI
41. Name of Business: TAMU
42. Business Mailing Address and Telephone Number
Street or P.O. Box: MS 1255 Telephone: (979) 862-4027
City: COLLEGE STATION State: TX Zip Code: 77840-1255
43. Business Location (If different from mailing address)
Number and Street: 1111 RESEARCH PKWY
City: COLLEGE STATION State: TX Zip Code: 77840-1255
44. Federal Tax Identification Number: X
45. Primary Standard Industrial Classifications (SIC) Code* (4 digit): X
46. Specific SIC Code* (4 digit): X
47. Texas Comptroller Taxpayer No.: X
48. Workers' Compensation Insurance Company
49. Policy Number
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date 5-12-03

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee
***Employers – Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.**

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex: F ☐ M ☒
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y): 09-09-1964
6. Does the Employee Speak English? If No, Specify Language: YES ☒ NO ☐
7. Race: White ☒ Black ☐ Asian ☐
8. Ethnicity: Hispanic ☐ Native American ☐ Other ☐
9. Mailing Address
Street or P.O. Box
City State Zip Code County
10. Marital Status: Married ☒ Widowed ☐ Separated ☐ Single ☐ Divorced ☐
11. Number of Dependent Children
12. Spouse's Name
13. Doctor's Name
14. Doctor's Mailing Address (Street or P.O. Box)
State TX Zip Code

15. Date of Injury (m-d-y): 3-2-03
16. Time of Injury: 10:00 am ☒ pm ☐
17. Date Lost Time Began (m-d-y): NLT
18. Nature of Injury*: EXPOSURE
19. Part of Body Injured or Exposed*: SYSTEM
20. How and Why Injury/Illness Occurred*: ALLEGED EXPOSURE OCCURRED WHEN AN AIR PACK HOSE SEPARATED AND CAUSED POSSIBLE EXPOSURE TO T.B.
21. Was employee doing his regular job? YES ☒ NO ☐
22. Worksite Location of Injury (stairs, dock, etc.)*: LAB
23. Address Where Injury or Exposure Occurred
Name of Business if incident occurred on a business site: LARR
Street or P.O. Box: MS 4473
County: BRAZOS
City: COLLEGE STATION
State: TX
Zip Code: 77843
24. Cause of Injury (fall, tool, machine, etc.)*: EXPOSURE
25. List Witnesses: NONE
26. Return to work date/or expected (m-d-y)
27. Did employee die? YES ☐ NO ☒
28. Supervisor's Name: STEPHEN STERLE
29. Date Reported (m-d-y): 03-02-2003

30. Date of Hire (m-d-y): 08-14-2000
31. Was employee hired or recruited in Texas? YES ☒ NO ☐
32. Length of Service in Current Position: Months 6 Years 2
33. Length of Service in Occupation: Months 6 Years 2
34. Employee Payroll Classification Code: 5067
35. Occupation of Injured Worker: ALAT
36. Rate of Pay at this Job: $ 9.10 Hourly $ 364.00 Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $ 728.00 For 80.00 Hours or _____ Days
39. Is employee an Owner, Partner, or Corporate Officer? Yes ☐ No ☒

40. Name and Title of Person Completing Form: KEVIN KARLI
41. Name of Business: TAMU
42. Business Mailing Address and Telephone Number
Street or P.O. Box: MS 1255
Telephone: (979) 862-4028
City: COLLEGE STATION
State: TX
Zip Code: 77843
43. Business Location (If different from mailing address)
Number and Street
City: COLLEGE STATION
State: TX
Zip Code: 77843
44. Federal Tax Identification Number: X
45. Primary Standard Industrial Classifications (SIC) Code* (4 digit): X
46. Specific SIC Code* (4 digit): X
47. Texas Comptroller Taxpayer No.: X
48. Workers' Compensation Insurance Company
49. Policy Number
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date 3-3-03

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee
***Employers – Do not send this form to the**
Texas Workers' Compensation Commission,
unless the Commission specifically requests a direct filing.

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex: F ☒ M ☐
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y): 04-10-1976
6. Does the Employee Speak English? If No, Specify Language: YES ☒ NO ☐
7. Race: White ☒ Black ☐ Asian ☐
8. Ethnicity: Hispanic ☐ Native American ☐ Other ☐
9. Mailing Address
Street or P.O. Box
City State Zip Code County
10. Marital Status: Married ☒ Widowed ☐ Separated ☐ Single ☐ Divorced ☐
11. Number of Dependent Children
12. Spouse's Name
13. Doctor's Name
14. Doctor's Mailing Address (Street or P.O. Box)
State TX Zip Code

15. Date of Injury (m-d-y): 3-19-03
16. Time of Injury: 14:00 am ☐ pm ☒
17. Date Lost Time Began (m-d-y): NLT
18. Nature of Injury*: EXPOSURE
19. Part of Body Injured or Exposed*: SYSTEM
20. How and Why Injury/Illness Occurred*:
EXPOSURE OCCURRED WHEN MICROTITER DISH CONTAINING BRUCELLA MELITENSIS CRACKED AND FELL CAUSING A SPILL.
21. Was employee doing his regular job? YES ☒ NO ☐
22. Worksite Location of Injury (stairs, dock, etc.)*: LAB
23. Address Where Injury or Exposure Occurred
Name of Business if incident occurred on a business site: TVEA
Street or P.O. Box: MS 4457
County: BZ
City: COLLEGE STATION
State: TX
Zip Code: 77840
24. Cause of Injury (fall, tool, machine, etc.)*: EXPOSURE
25. List Witnesses: NONE
26. Return to work date/or expected (m-d-y)
27. Did employee die? YES ☐ NO ☒
28. Supervisor's Name: TOM FICHT
29. Date Reported (m-d-y): 03-19-2003

30. Date of Hire (m-d-y): 11-21-2000
31. Was employee hired or recruited in Texas? YES ☒ NO ☐
32. Length of Service in Current Position: Months 4 Years 2
33. Length of Service in Occupation: Months 4 Years 2
34. Employee Payroll Classification Code: 9247
35. Occupation of Injured Worker: RESEARCH ASSIST 1
36. Rate of Pay at this Job: $ 9.60 Hourly $ 384.39 Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $ 1671.41 For _____ Hours or 30 Days
39. Is employee an Owner, Partner, or Corporate Officer? Yes ☐ No ☒

40. Name and Title of Person Completing Form: KEVIN KARLI
41. Name of Business: TAMU
42. Business Mailing Address and Telephone Number
Street or P.O. Box: MS 1255
Telephone: (979) 862-4027
City: COLLEGE STATION
State: TX
Zip Code: 77840-1255
43. Business Location (if different from mailing address)
Number and Street: 1111 RESEARCH PKWY
City: COLLEGE STATION
State: TX
Zip Code: 77840-1255
44. Federal Tax Identification Number: X
45. Primary Standard Industrial Classifications (SIC) Code* (4 digit): X
46. Specific SIC Code* (4 digit): X
47. Texas Comptroller Taxpayer No.: X
48. Workers' Compensation Insurance Company
49. Policy Number
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date 3-20-03

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee
***Employers – Do not send this form to the**
Texas Workers' Compensation Commission,
unless the Commission specifically requests a direct filing.

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex: F ☐ M ☒
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y): 12-10-1973
6. Does the Employee Speak English? If No, Specify Language: YES ☒ NO ☐
7. Race: White ☒ Black ☐ Asian ☐
8. Ethnicity: Hispanic ☐ Native American ☐ Other ☐
9. Mailing Address
Street or P.O. Box
City State Zip Code County
10. Marital Status: Married ☐ Widowed ☐ Separated ☐ Single ☒ Divorced ☐
11. Number of Dependent Children
12. Spouse's Name
13. Doctor's Name
14. Doctor's Mailing Address (Street or P.O. Box)
State TX Zip Code

15. Date of Injury (m-d-y): 2-3-03
16. Time of Injury: 13:40 am ☐ pm ☒
17. Date Lost Time Began (m-d-y): NLT
18. Nature of Injury*: EXPOSURE
19. Part of Body Injured or Exposed*: SYSTEM
20. How and Why Injury/Illness Occurred*: EMPLOYEE CAME IN CONTACT WITH A PERSON INFECTED WITH TUBERCULOSIS WHILE PERFORMING AN ARREST.
21. Was employee doing his regular job? YES ☒ NO ☐
22. Worksite Location of Injury (stairs, dock, etc.)*: DORM ROOM
23. Address Where Injury or Exposure Occurred
Name of Business if incident occurred on a business site: COPS
Street or P.O. Box: MS 1231
County: BRAZOS
City: COLLEGE STATION
State: TX
Zip Code: 77843
24. Cause of Injury (fall, tool, machine, etc.)*: EXPOSURE
25. List Witnesses: CLAY CRENSHAW
26. Return to work date/or expected (m-d-y)
27. Did employee die? YES ☐ NO ☒
28. Supervisor's Name: T ARMSTRONG
29. Date Reported (m-d-y): 02-03-2003

30. Date of Hire (m-d-y): 08-18-1997
31. Was employee hired or recruited in Texas? YES ☒ NO ☐
32. Length of Service in Current Position: Months _____ Years 6
33. Length of Service in Occupation: Months _____ Years 6
34. Employee Payroll Classification Code: 4205
35. Occupation of Injured Worker: POLICE OFFICER
36. Rate of Pay at this Job: $17.15 Hourly $ 686.00 Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $ 1372.00 For 80.00 Hours or _____ Days
39. Is employee an Owner, Partner, or Corporate Officer? Yes ☐ No ☒

40. Name and Title of Person Completing Form: KEVIN KARLI
41. Name of Business: TAMU
42. Business Mailing Address and Telephone Number
Street or P.O. Box: MS 1255
Telephone: (979) 862-4028
City: COLLEGE STATION
State: TX
Zip Code: 77843
43. Business Location (If different from mailing address)
Number and Street
City: COLLEGE STATION
State: TX
Zip Code: 77843
44. Federal Tax Identification Number: X
45. Primary Standard Industrial Classifications (SIC) Code* (4 digit): X
46. Specific SIC Code* (4 digit): X
47. Texas Comptroller Taxpayer No.: X
48. Workers' Compensation Insurance Company
49. Policy Number
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date 2-4-03

Form provided by Forms On-A-Disk, Inc. · Dallas, Texas · (214) 340-9429

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee
***Employers – Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.**

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex: F ☐ M ☒

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y): 09-23-1975

6. Does the Employee Speak English? If No, Specify Language
YES ☒ NO ☐

7. Race: White ☒ Black ☐ Asian ☐

8. Ethnicity: Hispanic ☐ Native American ☐ Other ☐

9. Mailing Address
Street or P.O. Box

City | State | Zip Code | County

10. Marital Status
Married ☐ Widowed ☐ Separated ☐ Single ☒ Divorced ☐

11. Number of Dependent Children

12. Spouse's Name

13. Doctor's Name

14. Doctor's Mailing Address (Street or P.O. Box)

State TX Zip Code

15. Date of Injury (m-d-y): 2-3-03

16. Time of Injury: 13:40 am ☐ pm ☒

17. Date Lost Time Began (m-d-y): NLT

18. Nature of Injury*: EXPOSURE

19. Part of Body Injured or Exposed*: SYSTEM

20. How and Why Injury/Illness Occurred*
EMPLOYEE CAME IN CONTACT WITH A PERSON INFECTED WITH TUBERCULOSIS WHILE PERFORMING AN ARREST.

21. Was employee doing his regular job? YES ☒ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)*

23. Address Where Injury or Exposure Occurred
Name of Business if incident occurred on a business site: COPS
Street or P.O. Box: MS 1231
County: BRAZOS
City: COLLEGE STATION
State: TX
Zip Code: 77843

24. Cause of Injury (fall, tool, machine, etc.)* EXPOSURE

25. List Witnesses
MATT JOSEPH

26. Return to work date/or expected (m-d-y)

27. Did employee die? YES ☐ NO ☒

28. Supervisor's Name: T ARMSTRONG

29. Date Reported (m-d-y): 02-03-2003

30. Date of Hire (m-d-y): 02-09-1995

31. Was employee hired or recruited in Texas? YES ☒ NO ☐

32. Length of Service in Current Position: Months _____ Years 8

33. Length of Service in Occupation: Months _____ Years 8

34. Employee Payroll Classification Code: 4208

35. Occupation of Injured Worker: POLICE OFFICER

36. Rate of Pay at this Job: $ 15.13 Hourly $ 605.20 Weekly

37. Full Work Week is: 40 Hours 5 Days

38. Last Paycheck was: $ 1210.40 For 80.00 Hours or _____ Days

39. Is employee an Owner, Partner, or Corporate Officer? Yes ☐ No ☒

40. Name and Title of Person Completing Form
KEVIN KARLI

41. Name of Business
TAMU

42. Business Mailing Address and Telephone Number
Street or P.O. Box: MS 1255
Telephone: (979) 862-4028
City: COLLEGE STATION
State: TX
Zip Code: 77843

43. Business Location (If different from mailing address)
Number and Street
City: COLLEGE STATION
State: TX
Zip Code: 77843

44. Federal Tax Identification Number
X

45. Primary Standard Industrial Classifications (SIC) Code* (4 digit)
X

46. Specific SIC Code* (4 digit)
X

47. Texas Comptroller Taxpayer No.
X

48. Workers' Compensation Insurance Company

49. Policy Number

50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date 2-4-03

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee
***Employers – Do not send this form to the**
Texas Workers' Compensation Commission,
unless the Commission specifically requests a direct filing.

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☒ M ☐

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 08-14-1971

6. Does the Employee Speak English? If No, Specify Language
YES ☒ NO ☐

7. Race White ☒ Black ☐ Asian ☐

8. Ethnicity Hispanic ☐ Native American ☐ Other ☐

9. Mailing Address
Street or P.O. Box

City State Zip Code County

10. Marital Status
Married ☐ Widowed ☐ Separated ☐ Single ☒ Divorced ☐

11. Number of Dependent Children

12. Spouse's Name

13. Doctor's Name

14. Doctor's Mailing Address (Street or P.O. Box)

State TX Zip Code

15. Date of Injury (m-d-y) 10-18-02

16. Time of Injury 8:30 am ☒ pm ☐

17. Date Lost Time Began (m-d-y) NLT

18. Nature of Injury* EXPOSURE

19. Part of Body Injured or Exposed* SYSTEM

20. How and Why Injury/Illness Occurred*
EMPLOYEE WAS INADVERTENTLY EXPOSED TO ANTHRAX POSITIVE TISSUES.

21. Was employee doing his regular job? YES ☒ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)* LAB

23. Address Where Injury or Exposure Occurred
Name of Business if incident occurred on a business site: TVMDL
Street or P.O. Box MS 4471 County
City COLLEGE STATION State TX Zip Code 77843

24. Cause of Injury (fell, tool, machine, etc.)* EXPOSURE

25. List Witnesses
TRAVIS MAYS, SID ANDERSON

26. Return to work date/or expected (m-d-y)

27. Did employee die? YES ☐ NO ☒

28. Supervisor's Name JOHN REAGOR

29. Date Reported (m-d-y) 10-21-2002

30. Date of Hire (m-d-y) 08-02-1999

31. Was employee hired or recruited in Texas? YES ☒ NO ☐

32. Length of Service in Current Position Months _____ Years 3

33. Length of Service in Occupation Months _____ Years 3

34. Employee Payroll Classification Code 5009

35. Occupation of Injured Worker VET LAB TECHNOLOGIST

36. Rate of Pay at this Job
$ 11.21 Hourly $ 448.40 Weekly

37. Full Work Week is:
40 Hours 5 Days

38. Last Paycheck was:
$ 896.80 For 80.00 Hours or _____ Days

39. Is employee an Owner, Partner, or Corporate Officer?
Yes ☐ No ☒

40. Name and Title of Person Completing Form
KEVIN KARLI

41. Name of Business
TAMU

42. Business Mailing Address and Telephone Number
Street or P.O. Box MS 1255 Telephone (979) 862-4028
City COLLEGE STATION State TX Zip Code 77843

43. Business Location (If different from mailing address)
Number and Street
City COLLEGE STATION State TX Zip Code 77843

44. Federal Tax Identification Number
X

45. Primary Standard Industrial Classifications (SIC) Code* (4 digit)
X

46. Specific SIC Code* (4 digit)
X

47. Texas Comptroller Taxpayer No.
X

48. Workers' Compensation Insurance Company

49. Policy Number

50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date 10-24-02

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee
***Employers – Do not send this form to the**
Texas Workers' Compensation Commission,
unless the Commission specifically requests a direct filing.

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex: F ☐ M ☒
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y): 06-14-1964
6. Does the Employee Speak English? If No, Specify Language: YES ☒ NO ☐
7. Race: White ☒ Black ☐ Asian ☐
8. Ethnicity: Hispanic ☐ Native American ☐ Other ☐
9. Mailing Address
Street or P.O. Box
City State Zip Code County
10. Marital Status: Married ☐ Widowed ☐ Separated ☐ Single ☒ Divorced ☐
11. Number of Dependent Children
12. Spouse's Name
13. Doctor's Name
14. Doctor's Mailing Address (Street or P.O. Box)
State TX Zip Code

15. Date of Injury (m-d-y): 10-18-02
16. Time of Injury: 14:00 am ☐ pm ☒
17. Date Lost Time Began (m-d-y): NLT
18. Nature of Injury*: EXPOSURE
19. Part of Body Injured or Exposed*: SYSTEM
20. How and Why Injury/Illness Occurred*: EMPLOYEE WAS INADVERTENTLY EXPOSED TO ANTHRAX POSITIVE TISSUES.
21. Was employee doing his regular job? YES ☒ NO ☐
22. Worksite Location of Injury (stairs, dock, etc.)*: LAB
23. Address Where Injury or Exposure Occurred
Name of Business if incident occurred on a business site: TVMDL
Street or P.O. Box: MS 4471
County
City: COLLEGE STATION State: TX Zip Code: 77843
24. Cause of Injury (fall, tool, machine, etc.)*: EXPOSURE
25. List Witnesses: DEBBIE DOOLEY,
26. Return to work date/or expected (m-d-y)
27. Did employee die? YES ☐ NO ☒
28. Supervisor's Name: DR VARNER
29. Date Reported (m-d-y): 10-23-2002

30. Date of Hire (m-d-y): 07-02-1990
31. Was employee hired or recruited in Texas? YES ☒ NO ☐
32. Length of Service in Current Position: Months _____ Years 12
33. Length of Service in Occupation: Months _____ Years 12
34. Employee Payroll Classification Code: 5005
35. Occupation of Injured Worker: TECH 1
36. Rate of Pay at this Job: $ 12.79 Hourly $ 511.60 Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $ 1023.20 For _____ Hours or _____ Days
39. Is employee an Owner, Partner, or Corporate Officer? Yes ☐ No ☒

40. Name and Title of Person Completing Form: KEVIN KARLI
41. Name of Business: TAMU
42. Business Mailing Address and Telephone Number
Street or P.O. Box: MS 1255
Telephone: (979) 862-4028
City: COLLEGE STATION State: TX Zip Code: 77843
43. Business Location (If different from mailing address)
Number and Street
City: COLLEGE STATION State: TX Zip Code: 77843
44. Federal Tax Identification Number: X
45. Primary Standard Industrial Classifications (SIC) Code* (4 digit): X
46. Specific SIC Code* (4 digit): X
47. Texas Comptroller Taxpayer No.: X
48. Workers' Compensation Insurance Company
49. Policy Number
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date 10-24-02

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee
***Employers – Do not send this form to the**
Texas Workers' Compensation Commission,
unless the Commission specifically requests a direct filing.

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)

2. Sex F ☐ M ☒

3. Social Security Number

4. Home Phone

5. Date of Birth (m-d-y) 10-06-1979

6. Does the Employee Speak English? If No, Specify Language
YES ☒ NO ☐

7. Race White ☒ Black ☐ Asian ☐

8. Ethnicity Hispanic ☐ Native American ☐ Other ☐

9. Mailing Address
Street or P.O. Box

City State Zip Code County

10. Marital Status
Married ☒ Widowed ☐ Separated ☐ Single ☐ Divorced ☐

11. Number of Dependent Children

12. Spouse's Name

13. Doctor's Name

14. Doctor's Mailing Address (Street or P.O. Box)

State TX Zip Code

15. Date of Injury (m-d-y) 10-6-79

16. Time of Injury 8:15 am ☒ pm ☐

17. Date Lost Time Began (m-d-y) NLT

18. Nature of Injury* EXPOSURE

19. Part of Body Injured or Exposed* SYSTEM

20. How and Why Injury/Illness Occurred*
EMPLOYEE WAS INADVERTENTLY EXPOSED TO ANTHRAX POSITIVE TISSUES.

21. Was employee doing his regular job? YES ☒ NO ☐

22. Worksite Location of Injury (stairs, dock, etc.)* LAB

23. Address Where Injury or Exposure Occurred
Name of Business if incident occurred on a business site: TVMDL
Street or P.O. Box MS 4471 County
City COLLEGE STATION State TX Zip Code 77843

24. Cause of Injury (fall, tool, machine, etc.)* EXPOSURE

25. List Witnesses
DEB DOOLEY

26. Return to work date/or expected (m-d-y)

27. Did employee die? YES ☐ NO ☒

28. Supervisor's Name JOHN REAGOR

29. Date Reported (m-d-y) 10-21-2002

30. Date of Hire (m-d-y) 08-08-2002

31. Was employee hired or recruited in Texas? YES ☒ NO ☐

32. Length of Service in Current Position Months 2 Years

33. Length of Service in Occupation Months 2 Years

34. Employee Payroll Classification Code 5005

35. Occupation of Injured Worker TOX TECH 1

36. Rate of Pay at this Job
$ 9.81 Hourly $ 372.40 Weekly

37. Full Work Week is:
40 Hours 5 Days

38. Last Paycheck was:
$ 784.80 For 80.00 Hours or _____ Days

39. Is employee an Owner, Partner, or Corporate Officer?
Yes ☐ No ☒

40. Name and Title of Person Completing Form
KEVIN KARLI

41. Name of Business
TAMU

42. Business Mailing Address and Telephone Number
Street or P.O. Box MS 1255 Telephone (979) 862-4028
City COLLEGE STATION State TX Zip Code 77843

43. Business Location (If different from mailing address)
Number and Street
City COLLEGE STATION State TX Zip Code 77843

44. Federal Tax Identification Number
X

45. Primary Standard Industrial Classifications (SIC) Code* (4 digit)
X

46. Specific SIC Code* (4 digit)
X

47. Texas Comptroller Taxpayer No.
X

48. Workers' Compensation Insurance Company

49. Policy Number

50. Did you request accident prevention services in past 12 months?
YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐

51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date 10-24-02

Form provided by Forms On-A-Disk, Inc. · Dallas, Texas · (214) 340-9429

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee
***Employers – Do not send this form to the**
Texas Workers' Compensation Commission,
unless the Commission specifically requests a direct filing.

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex: F ☐ M ☒
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y): 04-13-1943
6. Does the Employee Speak English? If No, Specify Language: YES ☒ NO ☐
7. Race: White ☐ Black ☐ Asian ☒
8. Ethnicity: Hispanic ☐ Native American ☐ Other ☐
9. Mailing Address: Street or P.O. Box
City | State | Zip Code | County
10. Marital Status: Married ☒ Widowed ☐ Separated ☐ Single ☐ Divorced ☐
11. Number of Dependent Children
12. Spouse's Name
13. Doctor's Name
14. Doctor's Mailing Address (Street or P.O. Box)
State TX Zip Code

15. Date of Injury (m-d-y): 10-18-02
16. Time of Injury: 14:00 am ☐ pm ☒
17. Date Lost Time Began (m-d-y): NLT
18. Nature of Injury*: EXPOSURE
19. Part of Body Injured or Exposed*: SYSTEM
20. How and Why Injury/Illness Occurred*: EMPLOYEE WAS INADVERTENTLY EXPOSED TO ANTHRAX POSITIVE TISSUES.
21. Was employee doing his regular job? YES ☒ NO ☐
22. Worksite Location of Injury (stairs, dock, etc.)*: LAB
23. Address Where Injury or Exposure Occurred
Name of Business if incident occurred on a business site: TVMDL
Street or P.O. Box: MS 4471
County
City: COLLEGE STATION | State: TX | Zip Code: 77843
24. Cause of injury (fall, tool, machine, etc.)*: EXPOSURE
25. List Witnesses: MICHAEL BEANEVAIS
26. Return to work date/or expected (m-d-y)
27. Did employee die? YES ☐ NO ☒
28. Supervisor's Name: LELVE GAYLE
29. Date Reported (m-d-y): 10-23-2002

30. Date of Hire (m-d-y): 03-26-1973
31. Was employee hired or recruited in Texas? YES ☒ NO ☐
32. Length of Service in Current Position: Months ____ Years 29
33. Length of Service in Occupation: Months ____ Years 29
34. Employee Payroll Classification Code: 7720
35. Occupation of Injured Worker: VET
36. Rate of Pay at this Job: $ 39.37 Hourly $ 1574.9 Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $ 6848.00 For ____ Hours or 30 Days
39. Is employee an Owner, Partner, or Corporate Officer? Yes ☐ No ☒

40. Name and Title of Person Completing Form: KEVIN KARLI
41. Name of Business: TAMU
42. Business Mailing Address and Telephone Number
Street or P.O. Box: MS 1255
Telephone: (979) 862-4028
City: COLLEGE STATION | State: TX | Zip Code: 77843
43. Business Location (If different from mailing address)
Number and Street
City: COLLEGE STATION | State: TX | Zip Code: 77843
44. Federal Tax Identification Number: X
45. Primary Standard Industrial Classifications (SIC) Code* (4 digit): X
46. Specific SIC Code* (4 digit): X
47. Texas Comptroller Taxpayer No.: X
48. Workers' Compensation Insurance Company
49. Policy Number
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date 10-24-02

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee
***Employers – Do not send this form to the**
Texas Workers' Compensation Commission,
unless the Commission specifically requests a direct filing.

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex: F ☒ M ☐
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y): 08-21-1974
6. Does the Employee Speak English? If No, Specify Language: YES ☒ NO ☐
7. Race: White ☒ Black ☐ Asian ☐
8. Ethnicity: Hispanic ☐ Native American ☐ Other ☐
9. Mailing Address
Street or P.O. Box
City State Zip Code County
10. Marital Status: Married ☒ Widowed ☐ Separated ☐ Single ☐ Divorced ☐
11. Number of Dependent Children
12. Spouse's Name
13. Doctor's Name
14. Doctor's Mailing Address (Street or P.O. Box)
State TX Zip Code

15. Date of Injury (m-d-y): 11-19-02
16. Time of Injury: 8:30 am ☒ pm ☐
17. Date Lost Time Began (m-d-y): NLT
18. Nature of Injury*: EXPOSURE
19. Part of Body Injured or Exposed*: HANDS AND ARMS
20. How and Why Injury/Illness Occurred*: POSSIBLE EXPOSURE FROM INFECTED LAB ANIMALS
21. Was employee doing his regular job? YES ☒ NO ☐
22. Worksite Location of Injury (stairs, dock, etc.)*: LAB
23. Address Where Injury or Exposure Occurred
Name of Business if incident occurred on a business site: HCSC
Street or P.O. Box: 1361
County: BRAZOS
City: COLLEGE STATION
State: TX
Zip Code: 77843
24. Cause of Injury (fall, tool, machine, etc.)*: EXPOSURE
25. List Witnesses: SUSAN MAIER
26. Return to work date/or expected (m-d-y)
27. Did employee die? YES ☐ NO ☒
28. Supervisor's Name: SUSAN MAIER
29. Date Reported (m-d-y): 11-20-2002

30. Date of Hire (m-d-y): 08-23-1993
31. Was employee hired or recruited in Texas? YES ☒ NO ☐
32. Length of Service in Current Position: Months _____ Years 3
33. Length of Service in Occupation: Months _____ Years 3
34. Employee Payroll Classification Code: 9247
35. Occupation of Injured Worker: RESEARCH ASSISTANT
36. Rate of Pay at this Job: $ 12.49 Hourly $ 499.86 Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $ 2173.50 For _____ Hours or 30 Days
39. Is employee an Owner, Partner, or Corporate Officer? Yes ☐ No ☒

40. Name and Title of Person Completing Form: KEVIN KARLI
41. Name of Business: TAMU
42. Business Mailing Address and Telephone Number
Street or P.O. Box: MS 1255
Telephone: (979) 862-4028
City: COLLEGE STATION
State: TX
Zip Code: 77843
43. Business Location (If different from mailing address)
Number and Street
City: COLLEGE STATION
State: TX
Zip Code: 77843
44. Federal Tax Identification Number: X
45. Primary Standard Industrial Classifications (SIC) Code* (4 digit): X
46. Specific SIC Code* (4 digit): X
47. Texas Comptroller Taxpayer No.: X
48. Workers' Compensation Insurance Company
49. Policy Number
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date 12-10-02

Form provided by Forms On-A-Disk, Inc. · Dallas, Texas · (214) 340-9429

Send the specified copies to your
Workers' Compensation Insurance Carrier
and the injured employee
***Employers – Do not send this form to the Texas Workers' Compensation Commission, unless the Commission specifically requests a direct filing.**

TWCC CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

1. Name (Last, First, M.I.)
2. Sex: F ☐ M ☒
3. Social Security Number
4. Home Phone
5. Date of Birth (m-d-y): 10-16-1979
6. Does the Employee Speak English? If No, Specify Language: YES ☒ NO ☐
7. Race: White ☒ Black ☐ Asian ☐
8. Ethnicity: Hispanic ☐ Native American ☐ Other ☐
9. Mailing Address
Street or P.O. Box
City State Zip Code County
10. Marital Status: Married ☐ Widowed ☐ Separated ☐ Single ☒ Divorced ☐
11. Number of Dependent Children
12. Spouse's Name
13. Doctor's Name
14. Doctor's Mailing Address (Street or P.O. Box)
City State TX Zip Code

15. Date of Injury (m-d-y): 1-28-03
16. Time of Injury: 8:45 am ☒ pm ☐
17. Date Lost Time Began (m-d-y): NLT
18. Nature of Injury*: EXPOSURE
19. Part of Body Injured or Exposed*: BODY SYSTEMS
20. How and Why Injury/Illness Occurred*: EMPLOYEE CAME IN CONTACT WITH AN ANIMAL BRAIN THAT TESTED POSITIVE FOR RABIES.
21. Was employee doing his regular job? YES ☒ NO ☐
22. Worksite Location of Injury (stairs, dock, etc.)*: LAB
23. Address Where Injury or Exposure Occurred
Name of Business if incident occurred on a business site: TVMDL
Street or P.O. Box: MS 4471
County: BRAZOS
City: COLLEGE STATION
State: TX
Zip Code: 77843
24. Cause of Injury (fall, tool, machine, etc.)*: EXPOSURE
25. List Witnesses: JANA DUKE, TRAVIS MAYS
26. Return to work date/or expected (m-d-y)
27. Did employee die? YES ☐ NO ☒
28. Supervisor's Name: JOHN REAGER
29. Date Reported (m-d-y): 01-28-2003

30. Date of Hire (m-d-y): 10-14-2002
31. Was employee hired or recruited in Texas? YES ☒ NO ☐
32. Length of Service in Current Position: Months 3 Years
33. Length of Service in Occupation: Months 3 Years
34. Employee Payroll Classification Code: 5005
35. Occupation of Injured Worker: TECH 1
36. Rate of Pay at this Job: $ 9.81 Hourly $ 392.40 Weekly
37. Full Work Week is: 40 Hours 5 Days
38. Last Paycheck was: $ 784.80 For 80.00 Hours or _____ Days
39. Is employee an Owner, Partner, or Corporate Officer? Yes ☐ No ☒

40. Name and Title of Person Completing Form: KEVIN KARLI
41. Name of Business: TAMU
42. Business Mailing Address and Telephone Number
Street or P.O. Box: MS 1255
Telephone: (979) 862-4028
City: COLLEGE STATION
State: TX
Zip Code: 77843
43. Business Location (if different from mailing address)
Number and Street
City: COLLEGE STATION
State: TX
Zip Code: 77843
44. Federal Tax Identification Number: X
45. Primary Standard Industrial Classifications (SIC) Code* (4 digit): X
46. Specific SIC Code* (4 digit): X
47. Texas Comptroller Taxpayer No.: X
48. Workers' Compensation Insurance Company
49. Policy Number
50. Did you request accident prevention services in past 12 months? YES ☐ NO ☐ If yes, did you receive them? YES ☐ NO ☐
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING)
X _____ Date 1-28-03