

Send the specified copies to
 Deep East Texas Self Insurance Fund
 and the injured employee.

*Employers – Do not send this form to the Texas Department of
 Insurance, Division of Worker's 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 <input type="checkbox"/> M <input type="checkbox"/>		15. Date of Injury (m-d-y) - -		16. Time of Injury : am <input type="checkbox"/> pm <input type="checkbox"/>		17. Date Lost Time Began (m-d-y)							
3. Social Security number - -		4. Home Phone ()		5. Date of Birth (m-d-y) - -		18. Nature of Injury*		19. Part of Body Injured or Exposed*							
6. Does the Employee Speak English? If No, Specify Language YES <input type="checkbox"/> NO <input type="checkbox"/>															
7. Race White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/>				8. Ethnicity Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/>						21. Was employee doing his regular job? YES <input type="checkbox"/> NO <input type="checkbox"/>		22. Worksite Location of Injury (stairs, dock, etc.)*			
9. Mailing Address Street or P.O. Box															
City		State		Zip Code		County									
10. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/>															
11. Number of Dependent Children				12. Spouse's Name						23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site Street or P.O. Box		County			
13. Doctor's Name										City		State		Zip Code	
14. Doctor's Mailing Address (Street or P.O. Box)										24. Cause of Injury(fall, tool, machine, etc.)*					
14. Doctor's Mailing Address (Street or P.O. Box)										25. List Witnesses					
City				State		Zip Code		26. Return to work date/or expected (m-d-y)		27. Did employee die? YES <input type="checkbox"/> NO <input type="checkbox"/>		28. Supervisor's Name		29. Date Reported (m-d-y) - -	

30. Date of Hire (m-d-y) - -		31. Was employee hired or recruited in Texas? YES <input type="checkbox"/> NO <input type="checkbox"/>		32. Length of Service in Current Position Months _____ Years _____		33. Length of Service in Occupation Months _____ Years _____			
34. Employee Payroll Classification Code				35. Occupation of Injured Worker					
36. Rate of Pay at this Job \$ _____ Hourly\$ Weekly		37. Full Work Week is: Hours _____ Days _____		38. Last Paycheck was: \$ _____ for _____ Hours or _____ Days		39. Is employee an Owner, Partner, or Corporate Officer? YES <input type="checkbox"/> NO <input type="checkbox"/>			

40. Name and Title of Person Completing Form Sandy Davis, Manager, HR Benefits				41. Name of Business Collin County Community College District							
42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone 3452 Spur 399, 3 rd Fl. (972) 599-3164				43. Business Location (If different from mailing address) Number and Street							
City McKinney		State TX		Zip Code 75069		City		State		Zip Code	
44. Federal Tax Identification Number 75-2037156		45. Primary North American Industry Classification System Code:(6 digit) 61121		46. Specific NAICS Code (6 digit) 8222		47. Texas Comptroller Taxpayer No. 999929184					
48. Workers' Compensation Insurance Company Deep East Texas Self Insurance Fund				49. Policy Number 0225							
50. Did you request accident prevention services in past 12 months? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> If yes, did you receive them? YES <input type="checkbox"/> NO <input type="checkbox"/>											
51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING) X _____ Date _____											





Deep East Texas Self Insurance Fund
Serving Texas since 1974

To be completed by Employer:

Employer Name: Collin County Community College

Claimant Name: _____

Bring this flyer with you to any network pharmacy to fill your workers' compensation prescription to ensure that you receive the right medications and the right treatment, *without out-of-pocket* expense.

For a participating pharmacy near you, call SCRIPNET at **888-880-8562** or logon to www.scripnet.com and click on "Find a Pharmacy".

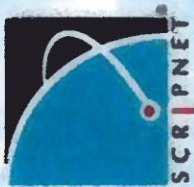
BROOKSHIRE BROTHERS • GEE SHIPMAN • COSTCO
CVS • H.E.B • LIFECHK • MEDICINE SHOPPE
RANDALL'S • SAM'S CLUB • SHOPKO
TOP FOOD & DRUG • TARGET • WALGREENS • WAL-MART
and MANY OTHERS...

PHARMACY: Call ScripNet at 888-880-8562



Rx BIN:	610621
Rx PCN:	SNT
Rx Grp:	Not Required
Carrier:	SXC

ID NUMBER: Call ScripNet at 1-888-880-8562



Find a Pharmacy in Your Neighborhood...

1.



Injured Workers

- [Find a Pharmacy](#)
- [Contact the Help Desk](#)

Go to www.scripnet.com and click on "Find a Pharmacy" at the bottom left of the screen. (There is no need to log in for this feature)

2.

Pharmacy Lookup

Search by City and State or Zip Code

City: State: OR Zip Code:

Note: Network pharmacy participation varies by plan. Please contact ScripNet at 1-888-880-8562 to determine if a particular pharmacy has opted into your plan.

Enter the City and State, or Zip Code of where you'd like to find a Pharmacy. Then, click on "Get Pharmacies"

3.

Pharmacy Lookup

Non-Scrip

Note: Network pharmacy participation varies by plan. Please contact ScripNet at 1-888-880-8562 to verify if a particular pharmacy has opted into your plan

Results for 10011

A'NSONIA PHARMACY
442 SIXTH AVENUE
NEW YORK, NY 10011
(212) 477-0762
[Map It!](#)

BIOSCRIP PHARMACY
179 4TH AVE
NEW YORK, NY 10011
(212) 691-5996

Select the pharmacy of your choice from the list provided, and click on the hyperlink "Map It!"

4.



You will be taken to a map of the location that you've chosen via MapQuest.com for driving directions!

Making Workers' Compensation Work Better™