

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"/>				20. How and Why Injury/Illness Occurred*					
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				23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site Street or P.O. Box County  City State Zip Code					
10. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/>				24. Cause of Injury(fall, tool, machine, etc.)*					
11. Number of Dependent Children		12. Spouse's Name		25. List Witnesses					
13. Doctor's Name				26. Return to work date/or expected (m-d-y)					
14. Doctor's Mailing Address (Street or P.O. Box)  City State Zip Code				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 Larry Merrill, Manager of 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 <sup>rd</sup> Fl. (972) 548-6664 City State Zip Code McKinney TX 75069				43. Business Location (If different from mailing address) Number and Street  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) <b>X</b> 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](http://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...

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**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](http://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

**MapQuest**

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) 477-0982  
[Map It!](#)

**BIOSCRIP PHARMACY**  
197 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™*