

THE UNIVERSITY OF TEXAS AT TYLER
SUPERVISOR'S FIRST REPORT OF INJURY

Please complete and submit this report immediately after you become aware of an injury or work-related illness of your employee. Type or print clearly in black ink. Return to Lynne Bandy, WCI Coordinator, ADM 108 or fax to (903) 565-5690. **DO NOT MAIL.** (If faxed, the original can be put in inter-campus mail.) If you have questions regarding this report, please call 566-7358.

TO BE COMPLETED BY SUPERVISOR – NOT THE EMPLOYEE

Employee's Full Name: _____ Job Title: _____

Department: _____ Immediate Supervisor _____ Ext. _____

Date and Time of Injury _____ Date and Time Reported _____

Was employee doing her/his usual job duties? ___ If the employee has had other similar incidents, how many? ___

Full Work Week is ___ hrs ___ days. In current position since (M/Y) ___

In current occupation since (M/Y) ___

What body parts did the employee report to you were injured? _____

What treatment was provided? () None () Dept. First Aid () Doctor's Visit () Hospital Visit

Doctor/Hospital Name/Address/Phone # _____

Date lost time began _____ Worksite location of injury (room, bldg, dock, etc) _____

Who witnessed the injury/incident? _____

Please attach their statements (if applicable.)

Describe where and how the injury occurred and what you think caused it: _____

Were appropriate preventive measure (equipment, teamwork, compliance with policy/procedure, etc.) being utilized when this injury occurred? Describe _____

Based on your investigation, what could have been done to prevent the injury? _____

Was there a direct violation of a departmental or institutional policy or procedure? Describe. _____

What corrective actions are being taken as a result of this injury? _____

What measures are being taken to prevent similar incidents in the future? _____

Supervisor's Signature

Print Supervisor's Name and Title

Date