



Employee's First Report of Work-Related Injury or Occupational Illness

Send completed First Report and Network Acknowledgement to wci@uttyler.edu .

Employee Information	
Injured Employee's Name: _____	Birthdate: _____
Home/Cell Phone #: _____	Work Phone #: _____
Personal Email Address: _____	Driver License #: _____
Street Address: _____	
City: _____	State: _____ Zip Code: _____
Preferred Language: _____	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed
If married, spouse's name: _____	# of Dependent Children _____
Job Title: _____	
Department in Which You are Employed: _____	
Were you working in that department when this incident occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, for which department were you working when the incident occurred? _____	
Incident Information	
Where did the incident happen? <input type="checkbox"/> Cafeteria <input type="checkbox"/> Exam Room <input type="checkbox"/> Hallway <input type="checkbox"/> Lab <input type="checkbox"/> Lobby <input type="checkbox"/> Nurses Station <input type="checkbox"/> Office <input type="checkbox"/> Parking Lot <input type="checkbox"/> Patient Room <input type="checkbox"/> Other (be specific) _____	
Occurrence Date: _____	Occurrence Time: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
What is your supervisor's name? _____	
Did you notify your supervisor about the occurrence? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what date? _____	
Were there any witnesses to the incident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, witness(es)' name(s) and phone number(s) is:	
Witness Name(s): _____ _____	Witness Phone Number(s) _____ _____
Did you seek medical treatment for this occurrence? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide the name, phone number, and address of the hospital/physician. ¹ _____	
Did you miss time from work because of this occurrence (<i>not including injury date</i>)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, have you returned to work? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what date did you return? _____	
What body part(s) were injured? (list is in alphabetical order left to right)	
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Ankle(s) <input type="checkbox"/> Arm(s) <input type="checkbox"/> Back <input type="checkbox"/> Buttock(s) <input type="checkbox"/> Chest
<input type="checkbox"/> Face	<input type="checkbox"/> Finger(s) <input type="checkbox"/> Foot/Feet <input type="checkbox"/> Hand(s) <input type="checkbox"/> Head <input type="checkbox"/> Hip(s)
<input type="checkbox"/> Knee(s)	<input type="checkbox"/> Leg(s) <input type="checkbox"/> Neck <input type="checkbox"/> Ribs <input type="checkbox"/> Shoulder(s) <input type="checkbox"/> Thigh(s)
<input type="checkbox"/> Wrist	<input type="checkbox"/> Other _____
Describe in detail how the incident happened and the nature of your injury or occupational disease (additional space on back): _____ _____ _____	

(continued on back)

¹ Note: If possible, care should be obtained through providers in the WorkWell, TX Network (see Network Acknowledgement).

(Incident Information continued)

The above statements are true and accurate to the best of my knowledge. I confirm that the occurrence described above happened while I was performing my essential job duties that were assigned to me at UT Health East Texas North Campus. I understand that information related to the incident, including the nature of the injury or occupational disease, may be shared with Occupational Health, Environmental Health and Safety, the Police Department, and/or Risk Management departments and other applicable departments for improvements in workplace safety and preventing future accidents and injuries.

Injured Employee's Signature

Date Signed

Supervisor's Signature

Date Signed

Injured employee and manager, please don't write below this line ↓. The information below will be added by Human Resources, if needed.

Human Resources

EE #: _____ DOH: _____ SSN: _____

Employment Status: PRN Compensation Status: Hourly Salary: Hourly _____

Job Title: _____

Department: _____

Manager: _____ Manager's Phone #: _____

Last Check Amount: _____ Last Check Hours: _____

Date Notice of Rights and Responsibilities Sent to Employee: _____

Did employee see a provider or miss time? Yes No If yes, date claim entered: _____

Claim #: _____ Date Reported to Provider: _____

If time missed, dates following items were submitted in ICE:

DWC 03: _____ DWC 06: _____

Notes: _____
