UTTyler
THE UNIVERSITY OF TEXAS AT TYLER

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: ❑ Single ❑ Married ❑ 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? ❑ Yes ❑ No If no, for which department were you working when the incident occurred? _____

Incident Information

Where did the incident happen? ❑ Cafeteria ❑ Exam Room ❑ Hallway ❑ Lab ❑ Lobby
❑ Nurses Station ❑ Office ❑ Parking Lot ❑ Patient Room
❑ Other (be specific) _____

Occurrence Date: _____ Occurrence Time: _____ ❑ AM ❑ PM

What is your supervisor's name? _____

Did you notify your supervisor about the occurrence? ❑ Yes ❑ No If yes, what date? _____

Were there any witnesses to the incident? ❑ Yes ❑ 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? ❑ Yes ❑ 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 (*not including injury date*)? ❑ Yes ❑ No

If yes, have you returned to work? ❑ Yes ❑ No If yes, what date did you return? _____

What body part(s) were injured? (list is in alphabetical order left to right)

❑ Abdomen	❑ Ankle(s)	❑ Arm(s)	❑ Back	❑ Buttock(s)	❑ Chest
❑ Face	❑ Finger(s)	❑ Foot/Feet	❑ Hand(s)	❑ Head	❑ Hip(s)
❑ Knee(s)	❑ Leg(s)	❑ Neck	❑ Ribs	❑ Shoulder(s)	❑ Thigh(s)
❑ Wrist	❑ 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 the UTHET North Campus Occupational Health (Occ Health) Clinic (ext. 7930). If the incident occurs when Occ Health isn't available or occurs off campus and you live in the service area, care needs to be obtained from a provider in the IMO 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 by The University of Texas System Administration and my employment department. 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: ❑ Regular, Full-Time ❑ Regular, Part-Time ❑ PRN

Compensation Status: ❑ Hourly ❑ Bi-Weekly ❑ Monthly

Salary: Hourly _____ Weekly _____ Monthly _____

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 entered in ICE: _____

Claim #: _____ Date Reported to Occ Health: _____

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

WCI 23 _____ DWC 03: _____ DWC 06: _____

Notes: _____