HealthPoint
Balance & Well-Being in Work & Life
Occupational Health Program

First Report of Incident
Injury Memorandum

Fax Completed form to 512.471.2666

Pay special attention to items marked with an asterisk (*), these items are explained in the instructions on the back of this form.

Name: _____ EID #:_____ Date of Birth: _____
Last name First name Middle initial

Sex (circle): Male / Female *Home Phone:_____ Email: _____

Does employee speak English? (Y/N) ____ If NO, specify language: _____

Mailing Address: _____
Street or P.O. Box City State Zip County (Travis, etc.)

*Marital Status (M/D/S/W): _____ Spouse's Name: _____ # of Dependent Children: _____

Occupation at time of incident: _____ Date of Hire: _____ Shift**:** (*circle one)* 1st 2nd 3rd other: _____

Length of Service in Current Position ____ yrs ____ mths Length of Service in Current Occupation ____ yrs ____ mths

Dept Name: _____ Supervisor's Name: _____ Supervisor Phone: _____

*Date of Incident: _____ Time of Incident: _____ am pm List Any Witnesses: _____

*Date Reported: _____ Reported to: _____ Body Part(s) Injured: _____

*Work Site Location of Incident (i.e., stairs, dock, lab, etc):_____

*Nature of Incident (e.g. fall, cut from knife, etc.): _____ Employee doing his/her regular job? (Y/N)____

*Cause of Incident (e.g. wet floor, broken tool/equipment, etc.):_____

Has the employee missed one day or more of work due to this injury? (Y/N) _____ *Date Lost Time Began: _____

*Return to Work Date: _____ Did the employee visit a doctor? (Y/N) ____ Doctor's Name: _____

Doctor's mailing address & office phone: _____

***Describe how the injury/illness occurred, including what the employee was doing prior to the incident:** _____

_____

_____

*Could this incident have been prevented? (Y/N) ____ If **YES**, explain how? _____

_____

Release of Information and Consent: I hereby authorize the UT Occupational Health Program (OHP), any consulting physicians and/or designates, and any insurance companies servicing the University of Texas, information from my medical records or from former workers' compensation carriers pertaining to the work-related injury/illness reported above. I hereby give my permission for this information to be used by the OHP to assist in claims management and implement return to work planning, as applicable.

_____ _____

Employee Signature **Date**

Supervisor's Signature: _____ **Date:** _____

Rv 11/9/16

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INSTRUCTIONS FOR FIRST REPORT OF INCIDENT-INJURY MEMORANDUM COMPLETION

When an occupational injury/illness occurs, this form is to be filled out and forwarded to your department Human Resources contact within 24 hours. It is important that all work-related injuries or illnesses be reported; complications may later arise from a very minor incident. Collected information can also be used to develop injury and illness prevention programming.

If doctor or hospital care is required, the incident must be called in immediately to the Benefits and Leave Management office at (512) 475-8099 OR the Occupational Health Program office at (512) 471-4647 so that the U.T. System Workers' Compensation Office can be notified.

Print in black ink or type each item on this form. The report should be signed by the employee and supervisor. If the employee is unable to sign the form at the time of the incident, the supervisor will request the employee's signature as soon as feasible.

All witnesses to an incident will be requested to give a written statement of what occurred. The supervisor should attach copies of witness reports in addition to any other reports/notes from the employee to the supervisor regarding the incident to the First Report of Incident-Injury Memorandum and send to the department HR contact. If the supervisor is unable to get a witness report on the same day as the incident, send it as soon as possible but do not delay in sending the First Report of Incident-Injury Memorandum.

Certain demographic information is required to file workers' compensation with the Texas Department of Insurance.

*** Phone** - If no home phone, please provide a phone number where the employee can be reached.

*** Marital Status** - M - married, S - Single, D - Divorced, SE - Separated, W – Widowed

*** Dates** - Enter all dates in month, day, year format (example: 05/25/04). Date of incident is the day of injury or the date an occupational illness was diagnosed as work related; the date reported is the day the employee reported the incident to their supervisor; the date lost time began is the first full day of lost time after the original date of injury. If no lost time, enter NLT.

*** Part of Body Injured** - List the **specific** body part (e.g. chin, right leg, forehead, left upper arm, etc). If more than one body part is affected, list each part.

*** Worksite Location of Incident** – Specific area within a building; include the location or address of where the injury occurred, e.g. 3rd floor copy center in NOA bldg.

*** Nature of Incident** - List nature of accident (e.g. fall from ladder, cut by knife, etc.)

*** Cause of Incident** - List object, substance, or exposure that directly inflicted the injury/illness (e.g. wet floor, material handling, chemical exposure, etc.).

*** How Incident Occurred** - Describe in detail (1) the events leading up to the injury, (2) how the injury occurred (e.g. employee slipped on wet floor), and (3) how it is work related. Please be as specific as possible. Use an additional sheet of paper if necessary.

***Injury Prevention** – Could the injury have been prevented? Consider the use of appropriate personal protective equipment (e.g. safety goggles, gloves, etc.), additional training on work & safety procedures, attention to detail, preventive maintenance on equipment, etc.