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

First Report of Incident
Injury Memorandum

Fax completed form to 512.471.7008

Employee Information (to be completed by employee)

Name: _____ EID: _____ Date of Birth: _____

Department: _____ Job Title: _____

Work Shift (e.g. 9am-5pm): _____ Preferred Language: _____

Gender: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Separated ☐ Divorced ☐ Widowed ☐ Married

# of Dependent Children: _____ Spouse's Name: _____

Race: ☐ White ☐ Black ☐ Asian ☐ Other Ethnicity: ☐ Hispanic ☐ Native American ☐ Other

Home Address: _____ City: _____

State: _____ Zip: _____ County: _____

Home Phone: _____ Email: _____

Incident Information (to be completed by employee)

Date of Incident: _____ Time of Incident: _____ ☐ AM ☐ PM Date Reported: _____

Building: _____ Floor / Room: _____ Work Area: _____

What were you doing at the time of the incident? _____

_____

Briefly describe exactly what caused the illness/injury (e.g. slipped on wet floor and fell, etc.): _____

_____

What type of injury or injuries did you receive (select all that apply)?

☐ Cut (Laceration) ☐ Scrape (Abrasion) ☐ Bruise (Contusion) ☐ Stick (Puncture) ☐ Crush ☐ Bite ☐ Sprain/Strain

☐ Slip/Trip/Fall ☐ Other (please describe your injury) _____

What did you injure? (e.g. left ring finger, right hip, etc) _____

_____

Were there any witnesses? ☐ No ☐ Yes (list name, phone #, and email of each witness) _____

_____

Did you seek treatment for the illness/injury? ☐ No ☐ Yes (list name and address of provider) _____

_____

Confirmation and Consent

I hereby confirm that the above information is true and correct to the best of my knowledge. I also authorize representatives from the University of Texas at Austin Occupational Health Program, any consulting physicians and/or their designates, and any insurance companies servicing the University of Texas, to release any and all information pertaining to this claim to the University of Texas' Workers' Compensation Insurance plan administrators and/or their designees.

Employee Signature: _____ Date: _____

Incident Information (to be completed by supervisor)

Was the employee doing his/her regular job at the time of the incident? ☐ Yes ☐ No (please explain) _____

_____

Was the employee using personal protective equipment (PPE) at the time of the incident? ☐ Yes ☐ No

Was the employee following established safety policies and procedures? ☐ Yes ☐ No (please explain) _____

_____

Has the employee missed one or more day(s) of work as a result of this incident? ☐ No ☐ Yes (please list date lost time began) _____

Has the already employee returned to work? ☐ No ☐ Yes (please list date of return) _____

Supervisor Information (to be completed by supervisor)

Name: _____ EID: _____

Department: _____ Job Title: _____

Work Phone: _____ Email: _____

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INSTRUCTIONS FOR THE FIRST REPORT OF INCIDENT- INJURY MEMORANDUM COMPLETION

When an occupational injury/illness occurs, this form is to be filled out by the employee in his/her primary language, signed by the employee's supervisor, and forwarded to the employee's department Human Resources (HR) contact within 24-48 hours of the injury. 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. For more information, please visit the Workers' Compensation Insurance page on the Human Resources website at http://www.utexas.edu/hr/current/insurance/wci/

It is important that all work-related injuries or illnesses be reported as complications may follow even the most minor incidents. This information may also be used to develop injury and illness prevention programming.

For injuries that result in an emergency, please call 911 and ask to be transported to the nearest emergency room (exposures to animal, chemical or biological hazards that result in an emergency should be referred to a St. David's affiliated emergency room).

For non-emergent injuries requiring first aid (minor cuts, bruises, sprains, and strains), please contact the on-campus Occupational Health Clinic at (512) 471-4647 and schedule an appointment with an Occupational Health Nurse.

For non-emergent injuries requiring more urgent care, employees may also may choose to visit an urgent care center or healthcare provider that participates in the IMO Network. To search for participating provider, please visit IMO's Find a Provider page at http://injurymanagement.com/imo-med-select-network/find-a-provider.

All witnesses to an incident should be asked to provide a written statement of what occurred. The supervisor should attach copies of witness statements and any other statements/notes from the employee regarding the incident to the First Report of Incident-Injury Memorandum. If the supervisor is unable to obtain a witness' statement on the same day as the incident, s/he should send the First Report of Injury and then attempt to obtain the witness statement as soon as possible.

In addition to this form, employees should also complete the Workers' Compensation Network Acknowledgement form.

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.

*** Dates** - Enter all dates in month/day/year format (i.e. 05/25/2017). 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 (examples: chin, right leg, forehead, left upper arm, etc). If more than one body part is affected, list each part.

*** How Incident Occurred** - Describe in detail (1) the events leading up to the injury, (2) how the injury occurred (examples: 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.