

## UT Health Science Center Tyler

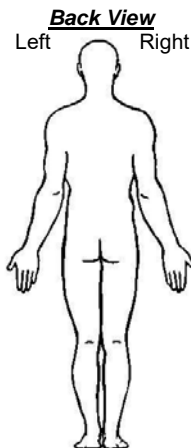
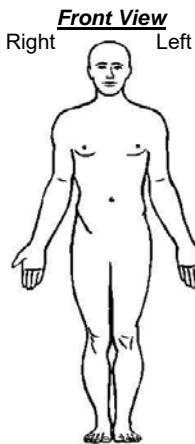
### Employee's First Report of Work-Related Injury or Occupational Disease

Employee Information	
Injured Employee's Name: _____	Male ( <input type="checkbox"/> ) Female ( <input type="checkbox"/> ) Date of Birth: ____/____/____
Home/Cell Phone: (____) _____	Work Phone: (____) _____ Preferred Language: _____
Employee ID: _____	Race: Asian ( <input type="checkbox"/> ) Black ( <input type="checkbox"/> ) White ( <input type="checkbox"/> ) Other ( <input type="checkbox"/> ) Ethnicity: Hispanic ( <input type="checkbox"/> ) Native American ( <input type="checkbox"/> ) Other ( <input type="checkbox"/> )
Work Email Address: _____	Personal Email Address: _____
Home Address: _____	City: _____ State: _____ Zip: _____
Marital Status: Married ( <input type="checkbox"/> ) Single ( <input type="checkbox"/> ) Widowed ( <input type="checkbox"/> )	Spouse's Name: _____ ( <input type="checkbox"/> ) NA # of dependent children? ____ ( <input type="checkbox"/> ) NA
Position/Title: _____	Employing Department: _____ Full Time ( <input type="checkbox"/> ) / Part Time ( <input type="checkbox"/> )

Incident Information	
Location where this occurrence happened? (Please be specific.) _____	
Address or name of building / location where this occurrence happened? _____	
Date of occurrence: _____	Time of occurrence: _____ ( <input type="checkbox"/> ) AM ( <input type="checkbox"/> ) PM Did you notify your supervisor? ( <input type="checkbox"/> ) Yes ( <input type="checkbox"/> ) No
Date Supervisor Notified: _____	Time _____ ( <input type="checkbox"/> ) AM ( <input type="checkbox"/> ) PM Name of Supervisor: _____
Were there any witnesses to this occurrence? ( <input type="checkbox"/> ) Yes ( <input type="checkbox"/> ) No _____	(____) _____ Witness Name Phone
Did you seek medical treatment for this occurrence? ( <input type="checkbox"/> ) Yes ( <input type="checkbox"/> ) No If Yes, List name, phone and address of hospital / physician: _____	
<b>*Employees who live in the network service area must seek medical attention from any physician or clinic within the Workers' Compensation Provider Network</b>	
Were days lost from work due to occurrence (not including injury date)? ( <input type="checkbox"/> ) Yes ( <input type="checkbox"/> ) No	
Have you returned to work? ( <input type="checkbox"/> ) Yes ( <input type="checkbox"/> ) No, Date Returned: ____/____/____	

**Please mark the areas of the body picture below that reflect where you were injured and check the appropriate boxes to the left.**

- (  ) Back
- (  ) Head
- (  ) Face
- (  ) Neck
- (  ) Shoulder
- (  ) Arm
- (  ) Wrist
- (  ) Hand
- (  ) Finger(s)
- (  ) Chest
- (  ) Abdomen
- (  ) Ribs
- (  ) Hips
- (  ) Buttocks
- (  ) Thigh
- (  ) Knee
- (  ) Leg
- (  ) Ankle
- (  ) Foot
- (  ) Other



Describe in detail the nature of your injury or occupational disease and how it happened (if more space needed, write on back of sheet)

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The above statement is 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 employing department. I understand that information related to the incident, including the nature of the injury or occupational disease, may be shared with Environmental Health and Safety and/or Risk Management departments and other applicable departments for improvements in workplace safety and preventing future accidents and injury.

Injured Employee's Signature	Date	Extension
Supervisor's Signature	Date	Extension

**Please email the completed First Report of Injury and completed UT Network Acknowledgement form to [benefits@uthct.edu](mailto:benefits@uthct.edu).**