THE UNIVERSITY OF TEXAS SAN ANTONIO / EMPLOYEE'S FIRST REPORT OF INJURY STATEMENT

[Please have employee complete.]

PLEASE PRINT

Name: ____ Social Security Number________________________ ☐ Male ☐ Female

Social Security Number
(1) with few exceptions, the individual is entitled on request to be informed about the information that the state governmental body collects about the individual;
(2) under Sections 552.021 and 552.023 of the Government Code, the individual is entitled to receive and review the information; and
(3) under Section 559.004 of the Government Code, the individual is entitled to have the state governmental body correct information about the individual that is incorrect.

Address:
Street____City___________________________County_____________________State__________Zip___________
Street or Box Apt.

Home Phone: (______) __________________ Campus Phone: (______) __________________ EID: ___________________ Date of birth:_______________

Marital Status: Married Spouse's name: ____

Widowed Single Separated Divorced Number of Dependents: __________

Date of Injury: _______________________ Time of Injury: _____________ AM PM Job Title: ____

Injury Location: ____
Building Area Floor Room No.

Explain how and why this injury occurred (Provide as much detail as possible)

Item or equipment involved in accident:

Type of injury: □ Burn □ Cut/Laceration □ Bruise □ Strain □ Needle stick □ Repetitive Motion □ Exposure
□ Bite □ Other ____ □ None (Incident Only)

Who witnessed the injury/illness/accident? Name(s) address and telephone number(s).

Were you advised of safety policies and procedures required for this job? □ Yes □ No □ Not Applicable Type of Shoes Worn:

If no, please explain: ____

Did you notify your supervisor? □ Yes □ No If YES, date and time of notification: __________________ ________________

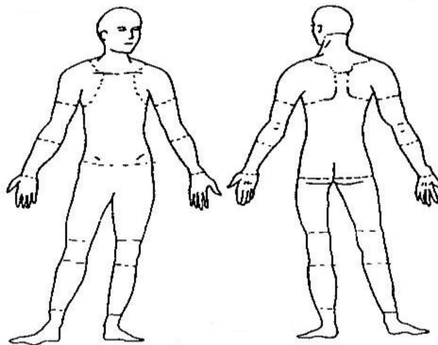
Department: _______________________ Supervisor: ____ Supervisor Phone: (_______) _________________

****I have been offered medical attention but do not wish to receive any at this time. ** (Initial here)** __________

If requesting medical treatment, who did YOU select as your treating doctor/facility? _____________________________________ Tel. No.__________________
Please fill out a "Notification of Injury" form and take it with you to the physician. Contact UT System Claims Analyst at 1-888-396-6844, ASAP.

Please designate the injured body part(s) as reported above.

□ Ankle □ Shoulder
□ Foot □ Upper Arm
□ Upper Leg □ Lower Arm
□ Lower Leg □ Elbow
□ Hip □ Wrist
□ Knee □ Hand
□ Toe(s) □ Fingers



□ Head □ Upper Back
□ Face □ Lower Back
□ Eye(s) □ Buttocks
□ Nose □ Abdomen (including groin)
□ Mouth □ Pelvis
□ Neck □ Chest

FORWARD COMPLETED FORM TO WCI OFFICE, ENVIRONMENTAL HEALTH, SAFETY & RISK MANAGEMENT, PH # 458-8178, FAX 458-7450

INFORMATION RELEASE

The above statement is true and accurate to the best of my knowledge. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me, or my health, to furnish to the U.T. System, UTSA Workers Compensation Office or its representative any and all information relevant to the injury or illness which I am reporting, including: medical history, consultation reports, hospital records, etc. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature of Employee: ____ Date: ______________________________