

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: (_____) _____

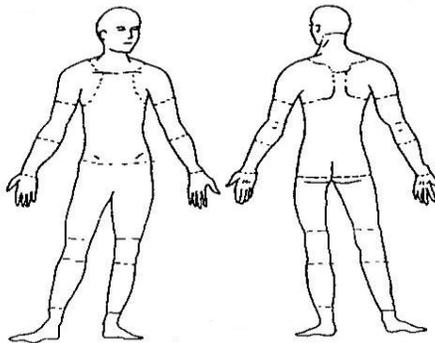
****I have been offered medical attention but do not wish to receive any at this time. ** (Initial here) _____**

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



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

FORWARD COMPLETED FORM TO WCI OFFICE, RISK & EMERGENCY 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: _____