

**THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER - HOUSTON
SUPERVISOR'S FIRST REPORT OF INJURY**

SOCIAL SECURITY NUMBER: _____ / _____ / _____

EMPLOYEE ID# _____

NAME: _____
Last First MI

HOME ADDRESS: _____

City _____ State _____ Zip Code _____

TELEPHONE: () _____ () _____
Work # Home #

BIRTHDATE: _____ / _____ / _____ SEX: Male Female
Month Day Year

MARITAL STATUS: Married Single Divorced Widow

Full Name of Spouse _____ Number of Dependents _____

INJURY DATE: _____ / _____ / _____
Month Day Year Day of Week

Time: _____ DEPARTMENT: _____
AM PM

TITLE: _____

INTEROFFICE ADDRESS: _____

POSITION: EMPLOYEE _____ RESIDENT _____ *STUDENT _____

Full Time Part Time (Check all that apply)

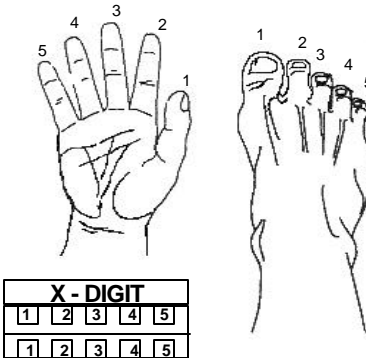
SUPERVISOR: _____

TELEPHONE: () _____ EXT.: _____

SUPERVISOR NOTIFIED OF INJURY: _____

Month Day Year Time AM PM

BODY PART AFFECTED			
MARK APPROPRIATELY	X - R - Right L - Left	R	L
<input checked="" type="checkbox"/>	Head		
	Face		
	Neck		
	Chest		
	Stomach		
	Lower Back		
	Upper Back		
	Groin		
	Coccyx		
	Other		
	Eye		
	Shoulder		
	Arm		
	Hand		
	Leg		
	Knee		
	Ankle		
	Foot		
	Toe		
	Finger		



INJURY TYPE	
MARK APPROPRIATELY	
<input checked="" type="checkbox"/>	Fall
	Needle Stick
	Exposure
	Sprain / Strain
	Burn
	Contusion / Bruise
	Bite**Describe Source Below
	Laceration / Cut
	Assault
	Eye Injury
	Rash
	Other-Describe Below

Describe the accident and how it occurred: _____

Names and departments of witnesses: _____

ACCIDENT LOCATION AREA			
BLDG	FLOOR	ROOM #	EXTERIOR LOCATION

GENERAL: (Mark an X in the appropriate areas)		
<input type="checkbox"/> OFFICE	<input type="checkbox"/> STAIRWELL	<input type="checkbox"/> OPERATING ROOM
<input type="checkbox"/> HALLWAY	<input type="checkbox"/> PARKING LOT/SIDEWALK	<input type="checkbox"/> OTHER: _____
<input type="checkbox"/> ELEVATOR	<input type="checkbox"/> LABORATORY	

I HAVE BEEN OFFERED MEDICAL TREATMENT, BUT DO NOT WISH TO RECEIVE ANY AT THIS TIME. _____ *PLEASE INITIAL.
 *(INITIALING DOES NOT PREVENT FUTURE TREATMENT IF NECESSARY.)

INFORMATION RELEASE

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, Department of Human Resources 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 Injured Party: _____ Date: _____

With few exceptions, you are entitled on your request to be informed about the information UTHSC-H collects about you. Under Sections 552.021 and 552.023 of the Texas Government Code, you are entitled to receive and review the information. Under Section 559.004 of the Texas Government Code, you are entitled to have UTHSC-H correct information about you that is held by us and that is incorrect, in accordance with the procedures set forth in The University of Texas System Business Procedures Memorandum 32. The information that UTHSC-H collects will be retained and maintained as required by Texas records retention law (Section 441.180, et. seq. of the Texas Government Code) and rules. Different types of information are kept for different periods of time.

By my signature below, I have examined this form and the information written above relating to my injury is true and correct.

Signature of Injured Party / Date

Signature of Supervisor / Date

ALL INFORMATION MUST BE COMPLETED BEFORE REPORT CAN BE PROCESSED

- Distribution:**
- Original - Workers' Compensation Insurance, UCT 1012C Phone: (713) 500-3392, Fax (713) 500-3396
 - Copy - HCPC Safety Office (Harris County Psychiatric Center-Injuries Only) Phone: (713) 741-7880
 - Copy - U.T. Health Services, UCT 1620/HCPC Case Manager/ Health Care Provider Copy Phone: (713) 500-3267, Fax (713) 500-3263
 - Copy - Department Copy

*Students are not covered under Workers' Compensation, this form is for record only.