

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

Other than signature please print. If you have questions about completing this form please call RMI 713-500-8127

ID# _____

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

NAME: _____
Last First MI

Time: _____ DEPARTMENT: _____
AM PM

HOME ADDRESS: _____

TITLE: _____

City _____ State _____ Zip Code _____

INTEROFFICE ADDRESS: _____

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

POSITION: EMPLOYEE _____ RESIDENT _____ *STUDENT _____
 Full Time Part Time (Check all that apply)

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

SUPERVISOR: _____

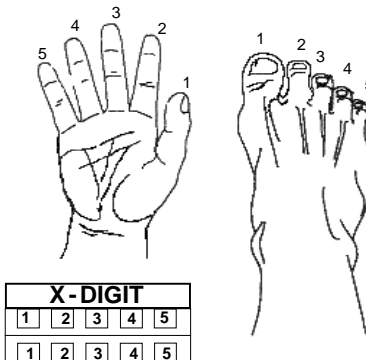
MARITAL STATUS: Married Single Divorced Widow

TELEPHONE: () _____ Pager: _____

SUPERVISOR NOTIFIED OF INJURY: _____ / _____ / _____
Month Day Year Time AM PM

Full Name of Spouse _____ Number of Dependents _____

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

Describe the accident and how it occurred: _____

Names and phones # 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 | |

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, Office of Risk Management 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: _____

- _____ **PLEASE INITIAL**, showing that you have been offered medical treatment, but do not wish to received any at this time. (initial- ing indicated that an opportunity to receive medical treatment was given, it does not prevent future treatment.
 - _____ **PLEASE INITIAL**, showing that you have received a copy of the Business Procedures Memorandum (BPM) 66-10-04 concern- ing confidentiality of your social security number.
 - _____ **PLEASE INITIAL**, showing that you have been received directions on how to choose a doctor from the Approved Doctor List. If you use any other doctor, other than in an emergency, you could be responsible for all bills incurred.
- 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

Disclosure of your Social Security Number (“SSN”) is required in order for The University of Texas System to report as required to the Texas Department of Insurance as mandated by state law. Further disclosure of your SSN is governed by the Public Information Act (Chapter 552 of the Texas Government Code) and other applicable law.

The following notices are being provided to you in accordance with Business Procedures Memorandum 66-10-04.

Section 7 of the Federal Privacy Act of 1974 (Historical Note, 5 U.S.C. § 552a)

DISCLOSURE OF SOCIAL SECURITY NUMBER

Section 7 of Pub. L. 93-579 provided that:

(a)(1) It shall be unlawful for any Federal, State or local government agency to deny to any individual any right, benefit, or privilege provided by law because of such individual's refusal to disclose his social security account number.

(2) [T]he provisions of paragraph (1) of this subsection shall not apply with respect to—

(A) any disclosure which is required by Federal statute, or

(B) the disclosure of a social security number to any Federal, State, or local agency maintaining a system of records in existence and operating before January 1, 1975, if such disclosure was required under statute or regulation adopted prior to such date to verify the identity of an individual.

(b) Any Federal, State, or local government agency which requests an individual to disclose his social security account number shall inform that individual whether that disclosure is mandatory or voluntary, by what statutory or other authority such number is solicited, and what uses will be made of it.”

§ 559.003. RIGHT TO NOTICE ABOUT CERTAIN INFORMATION LAWS AND PRACTICES.

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.

(a) Each state governmental body that collects information about an individual by means of a form that the individual completes and files with the governmental body in a paper format or in an electronic format on an Internet site shall prominently state, on the paper form and prominently post on the Internet site in connection with the electronic form, that:

(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.

(b) Each state governmental body that collects information about an individual by means of an Internet site or that collects information about the computer network location or identity of a user of the Internet site shall prominently post on the Internet site what information is being collected through the site about the individual or about the computer network location or identity of a user of the site, including what information is being collected by means that are not obvious.

Added by Acts 2001, 77th Leg., ch. 1059, § 1, eff. Sept. 1, 2001.

Choosing a Health Care Provider

To make it convenient for employees, you can go to UT Health Service located at 7000 Fannin, UCT 1620. Please call them at 713-500-3267 for treatment. UT Medical Foundation Residents can contact UT Medical School Health Services at 713-500-5171.

As another choice you may go any Health Care Provider who currently accepts Workers' Compensation. Please confirm this with them before setting up an appointment. If medical care is received from any unauthorized Health Care Provider, then you (the employee) will be responsible for any bills that are generated. Emergency treatment is an exception.

If you have questions concerning this, you may contact RMI (713-500-8100) or the Texas Department of Insurance, Division of Workers' Compensation Customer Assistance at 281-260-3035 or 713-924-2200.

After you have chosen your first treating doctor, you may not change doctors except with the approval of the Division. Any request to change doctors must be approved by the local Division office handling your claim. If it becomes necessary to change treating doctors for treatment of a work related injury, an Ombudsman at the TDI can assist you with this process. The Ombudsman may be reached by calling 281-260-3035 or 713-924-2200.

Please do not fax or send the 2nd or 3rd page of this document to RMI. Those pages need to be given to the employee. When the employee initials page 1, then this is the indication that they have received the 2nd and 3rd page of this document.