THE UNIVERSITY OF TEXAS SAN ANTONIO / EMPLOYEE'S FIRST REPORT OF INJURY STATEMENT
SUPERVISOR'S DETAILED DESCRIPTION OF INJURY / ILLNESS AND ACCIDENT SCENE

[Supervisor should complete.]

PLEASE PRINT

Injured Employee: _____ Injured Employee EID#_____

President's Office (includes Audit, Compliance and Risk Services; Equal Opportunity Services; and Office of Legal Affairs)

☐ President's Office ☐ ACRS ☐ EOS ☐ OLA

Vice Presidents

☐ Academic Affairs ☐ External Relations ☐ Business Affairs ☐ Community Services

☐ Research ☐ Student Affairs Associate/Assistant VP area or College: _____

Facilities

☐ Administration ☐ Downtown/HemisFair Park Campuses ☐ Engineering and Project Management

☐ Main Campus Housekeeping ☐ Main Campus Operations & Maintenance

Date of Injury: _____ Time of Injury: _____ AM PM Job Title: _____

Injury Location: _____
Building Area Floor Room No.

1. Describe the type of work area where the accident occurred (stairs, dock, office, hallway, street, etc.)
Please explain any unusual conditions that were present at the time of the injury.

2. Based on your inquires, explain how and why this injury occurred:

2a. Cause of injury (fall, tool, machine, ground, wet floor etc.) _____

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

4. Was employee doing his/her regular job? ☐ Yes ☐ No

5. Was there physical evidence of injury to the body part in question? ☐ Yes ☐ No

If yes, please describe (swelling, bruising, laceration etc.) _____

6. Does the employee speak English? ☐ Yes ☐ No If no, what language? _____

7. Injured employee's date of hire: _____ Occupation of Injured Worker: _____

Length of service in current position: _____ Length of service in Occupation: _____

8. Was the employee wearing personal protection equipment, which would have prevented the injury or occupational disease? ☐ Yes ☐ No ☐ Not Applicable

9. Was the employee advised of safety policies and procedures to prevent further occurrences? ☐ Yes ☐ No ☐ Not Applicable

10. Was medical treatment given to the employee? ☐ Yes ☐ No

11. Was the employee given the opportunity to choose their treating physician? ☐ Yes ☐ No ☐ Not Applicable

12. If taken for medical treatment, name of facility: _____

13. Did a department representative accompany the employee to the medical facility? ☐ Yes ☐ No ☐ Not Applicable

If yes, please provide the representative's name: _____

14. Has the employee lost time from work due to this injury? ☐ Yes ☐ No If yes, date lost time began: _____

14a. Has the employee returned to work? ☐ Yes ☐ No If yes, date returned to work: _____

The above statement is true and accurate to the best of my knowledge.

Supervisor Name: _____ Supervisor Signature: _____

Date: _____ Campus Ph. #: _____

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

REV 2/20