Instructions
Supervisor's First Report of Injury or Illness

Deadline for Submission: This form must be received by Risk Management within ***1 business day*** in order to meet state stipulated deadlines. Failure to submit the necessary forms on a timely basis may delay medical and income benefits to the injured employee and may result in administrative fines to the University. Please fax, mail via interoffice mail or deliver in person to Risk Management.

Completed by:
This form should be completed by the injured employee's supervisor or their designated representative.

Instructions/Responsibilities:

1. The supervisor or department designated representative must **completely fill out each section** of the form before submitting it to Risk Management. If not applicable, please fill out N/A.
2. This form must be signed and dated. Digital signatures are acceptable.
3. Get as many details as possible about the incident from the employee and witness(s).
4. Collect the completed *Employee's Report of Injury Form, Authorization for Release of Information Form, Employee's Election Form (if lost time anticipated), Associated Witness Statement and Workers Compensation Network Acknowledgement Form.*
5. If an employee loses any time from work due to the injury or returns to work in a modified duty capacity, notify Risk Management (713)743-5865 immediately. The supervisor should make every effort to accommodate any work **restrictions**.

   The Texas Business and Commerce Code defines a person's driver's license number & social security number along with their first name or first initial and last name as sensitive data. Per UH policy SAM 07.A.08 (Data Classification and Protection), sensitive data such as that defined in the Texas Business and Commerce Code is level 1 data and must not be transmitted by email unless the message is encrypted. To receive a digital certificate necessary to send encrypted email, contact Brian Walker, manager of UIT Security, at bmw@uh.edu.

   Sending non-encrypted messages with level 1 data is a *violation* of UH policy and state law and will not be accepted for processing.

Send to:

Workers' Compensation
Specialist
Risk Management
E. W. Cullen Bldg Room 22D
Fax: 713-743-1501
Phone: 713-743-5865
Please email workerscomp@uh.edu

Questions:

UNIVERSITY of HOUSTON
DEPARTMENT OF RISK MANAGEMENT

SUPERVISOR'S FIRST REPORT OF INJURY OR ILLNESS

This form must be completed and signed by the supervisor or designated representative, not the employee, and submitted **within 24 hours** to the Claims Coordinator by fax to 713-743-1501, or deliver in person to Risk Management, General Services Building, Room 183, or by interoffice mail code 1005.

Name: (Last, First, M.I.)	Empl I.D.#	Gender: Male ☐ Female ☐	Race:
Social Security Number:	Home Phone:	Date of Birth:	Speak English? YES ☐ NO ☐
Employee's Work Telephone Number/Department Name:		Home/Mailing Address:	
Marital Status: ☐ Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced	Number of Dependent Children:	Spouse's Name:	
Treating Doctor's Name (if medical treatment involved):	Clinic Address:	Telephone Number:	
Date of injury (m-d-y):	Time of injury: _____ ☐ AM ☐ PM	Date Lost Time Began (if applicable):	
Type of Injury: (example: sprain, burn, contusion, laceration, fracture, puncture)		Part of body injured or exposed: (Please be specific – e.g. right middle finger, left ankle, upper back)	
Describe in detail how the accident occurred: (Describe the work process the employee was engaged in. Give the purpose of the function or task, describe how the injury occurred, and explain the cause). Attach additional sheets if necessary:			
Was the employee doing his or her regular job? YES ☐ NO ☐	Location of accident: Building #:	Room No.:	Area: (hallway, office, parking lot, etc.)
Cause of injury: (fall, tool, machine, etc.)		List Witnesses: (Name/Phone #)	
Return to work date:	Did employee die? YES ☐ NO ☐	Supervisor's Name:	Phone #:
Date reported:	Date of hire:	Rate of Pay: $ hrly./mth.	Full Work Week: _____ Hrs _____Days
Length of service in current position: Years _____ Months _____	Length of Service in Occupation Years _____ Months _____		
Employee's Title:	Number of hours of sick/vacation accrued on date of injury: Sick hrs. Vacation hrs.		
Do you agree with the employee's description of the accident? YES ☐ NO ☐			
If no, explain:			
Was safety equipment provided? (if applicable) YES ☐ NO ☐	Was safety equipment used (if applicable)? YES ☐ NO ☐		
If no, explain:			
Action taken to prevent this accident from reoccurring **(must be completed):**			
Name of Supervisor:	Title:	Work phone number:	
Signature of supervisor/designated representative: X		Date:	

Questions? Call 713-743-0414 or email workerscomp@uh.edu. See also http://www.uh.edu/af/riskmanagement/workerscomp.htm