WE MAKE LIVES BETTER
UT HEALTH SCIENCE CENTER™
SAN ANTONIO

For Office Use (Claim No.):_______________

THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO
ENVIRONMENTAL HEALTH & SAFETY
PH. 567-2955/ FAX 567-2965

EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

TO BE COMPLETED BY DEPARTMENT

SUBMIT TO ENVIRONMENTAL HEALTH & SAFETY WITHIN 24 HOURS OF NOTICE BY EMPLOYEE

1. Employee Name (Last, First, MI): ______________________________

2. Employee ID#: ____________________ **3.** Sex: ☐Male ☐Female

4. Department: ____________________ **5.** Job Title: ____________________

6. Home Information: ______________________________
Street Address

____
City State Zip Code County

____________________ ____________________
Home Phone Number Work Phone Number

7. Supervisor's Name:____________________ **8.**Supervisor's Phone: ____________________

9. Race: ☐White ☐Black ☐ Asian **10.** Date of Birth (m,d,y): ______________

11. Ethnicity: ☐Hispanic ☐American Indian ☐Other

12. Marital Status: ☐Married ☐Single

13. Spouse's Name: ____________________**14.** No. of Dependent Children: ________

15. Doctor: (List doctor treating injury or illness) If no doctor seen, check here☐

____
Name Phone No.

____
Street

____
City State Zip Code

16. Date of Injury: (m,d,y)______________ **17.** Time of Injury: __________AM __________PM

18. First Full Day/Shift of Lost Time: (m,d,y) ______________

19. Nature of Injury (cut, sprain, burn, etc.): ______________________________

20. Part(s) of Body Injured or Exposed (list **all** and be very specific, e.g.,right upper arm, left middle finger, upper back, lower back): ____

____

21. How and Why Injury/Illness Occurred: ____

____

____

22. Was employee doing regular job? ☐Yes ☐No

23. Worksite Location of Injury (stairs, dock, hallway, etc.): ______________________________

____

24. Address of Injury: ____

Street Apt. No.

____

City State Zip Code

25. Cause of Injury (tool, slippery floor, machine): ______________________________

26.Witnesses: ______________________________ Phone: ____________________

______________________________ Phone: ____________________

27. Date Reported to Department by Employee (m,d,y): ______________________________

28. Date Employee Released by Physician to Return to Work (m,d,y): ____________________

29. Date of Hire at UTHSCSA (m,d,y): ____________________

30. Beginning Date in Current Title: (m,y): __________________

31. Beginning Date in Occupation (if before working at UTHSCSA, give that date (m,y): _______________

32. Hours Worked Weekly:_________________ **33**. Last Paycheck (gross): _______________ (Include Longevity Pay)

34. Rate of Pay at Time of Injury (monthly or hourly gross): ______________________________

35. Department Representative Information:

Name________________________________ **Title**______________________________________

(Please print)

Signature ____ **Date** ____________________

36. Injured Employee's Information:

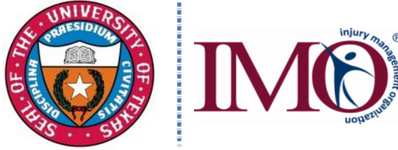
Name________________________________ **Title**______________________________________

(Please print)

Signature ____ **Date** ____________________

For Office Use Only: Initials___________ Date Entered___________ EH&S 03/09

The University of Texas Health Science Center – San Antonio



Workers' Compensation Network
Acknowledgement Form

I have received information (Employee Welcome Letter, Notice of Network Requirements and Employee Handbook Material) which informs me how to get Health Care under Workers' Compensation Insurance.

If I am hurt on the job and live in the service area described in this information, I understand that:

1. I must choose a Treating Doctor from the list of physicians in the ***IMO Med-Select Network***®**.** Or, I may ask my HMO primary care physician to agree to serve as my treating doctor by completing the Selection of HMO Primary Care Physician as Workers' Compensation Treating Doctor Form # IMO MSN-5.
2. I must go to my Network Treating Doctor for all Health Care for my injury. If I need a specialist, my Treating Doctor will refer me. If I need emergency care, I may go anywhere.
3. The insurance carrier will pay the Treating Doctor and other Network providers.
4. I *may have to pay* the bill if I get Health Care from someone other than a Network doctor without Network approval.
5. If an employee receives the Notice of Network Requirements and refuses to sign the Acknowledgement form, *they are still required to use the network*.

Please fill out the following information before signing and submitting this completed acknowledgement form:

Name of Carrier: The University of Texas System

Employee ID #: ____________________________ **Name of Network:** IMO Med-Select Network®

Hire Date: ________________________________ **Department**: ____________________________

Home Address: ____

Street Address – No P.O. Box or Work Address

____

City **State** **Zip Code** **County**

____ ______________________

Employee Signature **Date**

____ ______________________

Printed Name **Employee Phone Number**

Contact James Borrego- WCI Administrator at 567-2986