

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 \_\_\_\_\_