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 DEPARTMENT
PH. (210) 567-2955/ FAX (210) 567-2965

SUPPLEMENTAL REPORT OF INJURY

TO BE COMPLETED BY DEPARTMENT (SUBMIT TO ENVIRONMENTAL HEALTH & SAFETY DEPARTMENT)

1. Employee Name:_____ 2. Employee ID #.:_____ 3. Date of Injury:_____

4. Employee's Mailing Address:_____
Street or P.O. Box

_____
City State Zip Code

INSTRUCTIONS: Check the box that shows the reason for completing this Supplemental Report of Injury:

☐ Employee returned to work
Complete 5a or 5c
Complete 6, 7 and 8

☐ Additional day(s) of disability
Complete 5c
Complete 7 and 8

☐ Change in weekly earnings after injury
Complete 5a or 5c
Complete 7 and 8

☐ Employee terminated/resigned
Complete 5a or 5c
Complete 7, 9 and 10

5. a) If initial filing of the Supplemental Report of Injury, first day of disability due to injury (m,d,y)_____

b) If applicable, the eighth day of disability began on (m-d-y)_____

c) If second or subsequent filing of Supplemental Report of Injury, give first day of disability due to injury for this period only (m,d,y)_____

6. Date of Return to Work:_____

☐ Full Duty, Full Pay ☐ Limited Duty, Full Pay ☐ Reduced Pay

7. Weekly and Hourly Earnings at Time of This Report: Weekly: $_____ Hourly: $_____

☐ Same as Pre-injury Wages ☐ Increase from Pre-injury Wages ☐ Decrease from Pre-injury Wages

8. No. of Hours Working Weekly at Time of this Report : _____

☐ Same as Pre-injury Hours ☐ Increase from Pre-injury Hours ☐ Decrease from Pre-injury Hours

9. Upon the employee's resignation, termination or death, fill in the appropriate information.

☐ Resignation date (m-d-y) _____ ☐ Termination date (m-d-y) _____ ☐ Date of Death (m-d-y) _____

a) Reason for Resignation or Termination _____

b) Was employee on limited duty at the time of termination? ☐ Yes ☐ No

10. No. of Hours Working Weekly at Time of Resignation, Termination or Death: _____

☐ Same as Pre-injury Hours ☐ Increase from Pre-injury Hours ☐ Decrease from Pre-injury Hours

Department:_____ **Dept. Signature:**_____ **Date:**_____