Stephen F. Austin State University, a member of The University of Texas System
Employee's First Report of Work-Related Injury or Occupational Disease

Employee Information

Injured Employee's Name: _____ Male ☐ Female ☐ Date of Birth: ____/ ____/ _____

Home/Cell Phone: (_____) _____ Work Phone: (_____) _____ Preferred Language: _____

Employee ID: _____ Race: Asian ☐ Black ☐ White ☐ Other ☐ Ethnicity: Hispanic ☐ Native American ☐ Other ☐

Work Email Address: _____ Personal Email Address: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Marital Status: Married ☐ Single ☐ Widowed ☐ Spouse's Name: _____ ☐ NA # of dependent children? ___ ☐ NA

Position/Title: _____ Employing Department: _____ Full Time ☐ / Part Time ☐

Incident Information

Location where this occurrence happened? (Please be specific.) _____

Address or name of building / location where this occurrence happened? _____

Date of occurrence: _____ Time of occurrence: _____ ☐ AM ☐ PM Did you notify your supervisor? ☐ Yes ☐ No

Date Supervisor Notified: _____ Time _____ ☐ AM ☐ PM Name of Supervisor: _____

Were there any witnesses to this occurrence? ☐ Yes ☐ No _____ (_____) _____
Witness Name Phone

Did you seek medical treatment for this occurrence? ☐ Yes ☐ No If Yes, List name, phone and address of hospital / physician:

_____

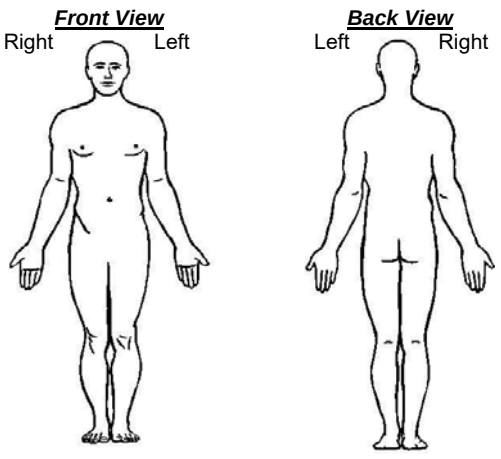
***Employees who live in the network service area must seek medical attention from any physician or clinic within the Workers' Compensation Provider Network**

Were days lost from work due to occurrence (not including injury date)? ☐ Yes ☐ No

Have you returned to work? ☐ Yes ☐ No, Date Returned: ____/ ____/ _____

Please mark the areas of the body picture below that reflect where you were injured and check the appropriate boxes to the left.

- ☐ Back
- ☐ Head
- ☐ Face
- ☐ Neck
- ☐ Shoulder
- ☐ Arm
- ☐ Wrist
- ☐ Hand
- ☐ Finger(s)
- ☐ Chest
- ☐ Abdomen
- ☐ Ribs
- ☐ Hips
- ☐ Buttocks
- ☐ Thigh
- ☐ Knee
- ☐ Leg
- ☐ Ankle
- ☐ Foot
- ☐ Other



Describe in detail the nature of your injury or occupational disease and how it happened (if more space needed, write on back of sheet)

_____

_____

_____

_____

_____

_____

_____

The above statement is true and accurate to the best of my knowledge. I confirm that the occurrence described above happened while I was performing my essential job duties that were assigned to me by The University of Texas System Administration and my employing department. I understand that information related to the incident, including the nature of the injury or occupational disease, may be shared with Environmental Health, Safety & Risk Management department and other applicable departments for improvements in workplace safety and preventing future accidents and injury.

_____ _____ _____
Injured Employee's Signature Date Extension

_____ _____ _____
Supervisor's Signature Date Extension

Please email the completed First Report of Injury and completed IMO Network Acknowledgement form to Workers' Compensation at WCI@sfasu.edu