UNIVERSITY OF TEXAS ARLINGTON

Environmental Health and Safety

Form CO-EHS-F401
11/2023

University of Texas at Arlington

Employee's Report of Work-Related Injury or Occupational Disease

Personal Information:

Employee Name: _____ UT EID: _____ Email Address: _____

Home Phone: _____ Mailing Address: _____ City: _____Zip: _____

Work ext. or best number to reach you during working hours: _____

Date of Birth: _____ □ Male □ Female Race: □ Black □ White □ Asian □ NA

Marital Status: □ Married □ Unmarried □ Separated Spouse's Name: _____ □ NA # Dependent Children? _____ □ NA

Position/Title: _____ Department Where Employed: _____

Incident Information:

Date of Injury: _____ Time of Injury: _____ □ a.m. □ p.m. Date Supervisor was notified: _____

Direct Supervisor's Name: _____ Direct Supervisor Contact Number: _____

Name of management you reported the injury to, if different than direct supervisor: _____

Contact Number: _____

Worksite location of injury (Ex.: Administration Bldg., Sidewalk, Corridor by 2nd floor elevators, Lab, etc.)

Building/Room#_____ Description of Area_____

If off campus, location and physical address: _____

Describe below how the injury or exposure occurred. (Ex.: I left my office walking to the elevator, my shoe caught on carpeted hallway, and I tripped/fell striking right shoulder on floor OR I struck the top of my left hand with a screwdriver while trying to put together a desk for my office.)

Describe the resulting 'physical' injury (s) (Ex.: sprained left ankle, bruised left shoulder, laceration on top of head)

Did anyone witness the injury? Yes □ No □ List witness name (s) and contact information below.

1. _____ Contact # or email _____

2. _____ Contact # or email _____

3. _____ Contact # or email _____

Please select all body parts where you were injured and check the appropriate boxes.

	Left	Right	Both			Left	Right	Both
Abdome/Stomach □	□	□	□		**Head** □	□	□	□
Ankle □	□	□	□		**Hip** □	□	□	□
Arm □ **upper** □ **lower** □	□	□	□		**Knee** □	□	□	□
Back □ **upper** □ **lower** □	□	□	□		**Leg** □ **upper** □ **lower** □	□	□	□
Buttocks □	□	□	□		**Multiple Body Parts** □	□	□	□
Chest (includes ribs/sternum) □	□	□	□		**Neck** □	□	□	□
Ear □	□	□	□		**Nose** □	□	□	□
Elbow □	□	□	□		**Sacrum/Coccyx Tailbone** □	□	□	□
Eye □	□	□	□		**Shoulder** □	□	□	□
Face □	□	□	□		**Throat** □	□	□	□
Foot □	□	□	□		**Teeth** □	□	□	□
Hand □	□	□	□		**Wrist** □	□	□	□
Finger thumb □ **index** □ **middle** □ **ring** □ **little (pinky)** □					**Toe 1st** □ **2nd** □ **3rd** □ **little toe** □ **great toe** □			

Medical Information:

Please complete and return the Workers' Compensation Network Acknowledgement Form which informs you how to get healthcare under workers' compensation insurance. Please review the Notice of Network Requirements and obtain the WC Pharmacy First Fill /Text2Fill form.

I have been offered medical treatment but do not wish to receive any now. Initials_____
I understand this does not prevent me from seeking medical treatment later.

If seeking initial medical treatment, please provide the information below:

_____
Clinic or Hospital Name

_____
Physician

_____
Phone

_____
Address of clinic:

The above statement is true and accurate to the best of my knowledge. I confirm that the accident described above happened while I was performing duties that were assigned to me by UTA (University of Texas Arlington).

I understand that information related to the incident, including the nature of the injury or occupational disease, may be shared with the Environmental Health and Safety and/or other UTA/UT System depts. for improvements in workplace safety and preventing accidents and injury. It may also be shared with Office of Talent, Culture, and Inclusion for designation of Family Medical Leave, if applicable.

Injured Employee's Signature_____ Date _____

Scan and email completed form to workerscompensation@uta.edu.