Instructions
Employee's Report of Injury

Deadline for Submission:
If possible, provide a verbal description of the accident to your supervisor, immediately after the accident. This form should be completed and submitted within ***2 business days***.

Completed by:
This form shall be completed by the injured employee. If the employee is incapacitated the spouse, child or legal guardian may sign the form. This form must be signed and dated.

Instructions:
1. The employee will address each of the questions completely and should use additional pages if necessary.
2. This form must be signed and dated.
3. **Give this form to your supervisor or their designated representative.**

Medical Treatment:

If emergency medical treatment is required:
You can seek treatment at any hospital emergency room. Immediately following your initial treatment, please complete the Employee's Report of Injury form and forward it to your supervisor.

Non-emergency medical treatment:
You can see any medical provider that accepts Workers' Compensation Insurance and is listed within the CompKey + Healthcare Network. A link to finding a Healthcare Network Provider is available on the Risk Management website:

http://www.uh.edu/af/riskmanagement/healthcare.htm

The State Office of Risk Management (SORM) administers the University's workers' compensation program. A SORM adjuster will call you to investigate the incident. Provide as many details about the accident as you can. It will aid the adjuster in determining whether your injury is compensable under the Texas Workers' Compensation Law.

SORM
STATE OFFICE of RISK MANAGEMENT

EMPLOYEE'S REPORT OF INJURY

Dear Employee:

We have received a report that you were injured in the course of your employment. To process your claim efficiently, please fill in all lines completely and print legibly. **Attach additional sheets if necessary.**

Name: _____ (Last / First / MI / Maiden)
Address: _____
City: _____ State: _____
Primary Phone Number: _____
Secondary Phone Number: _____
Email address: _____

Social Security: _____ Gender: M / F
Date of Injury: _____
Employer: _____
Job Title: _____
Work Schedule: _____

1) What was the exact location of the accident (street address if possible):

2) What was happening at the time? (What was going on around you, what were you doing, what were other people doing)

3) Briefly describe what exactly caused the injury:

4) What areas of your body were injured?

5) When and to whom did you report your injury? Date _____ Time _____
Name: _____ Title _____ Phone Number: _____

6) List all known witnesses. (Continue on back if necessary) Name _____ Phone: _____
Name _____ Phone: _____ Name: _____ Phone: _____

7) Please identify your Primary Care Physician or family doctor: Name: _____ Phone: _____

8) Please list the names and phone numbers of all doctors or treatment providers you have seen for your injury:
Name: _____ Phone: _____
Name: _____ Phone: _____
Name: _____ Phone: _____

9) Has a doctor taken you off work? ☐ Yes ☐ No If so, when was the first day you missed work ? _____

10) If the doctor took you off work, have you returned to work? ☐ Yes ☐ No If not, when do you think you will return to work? _____

11) Date of Last Appointment: _____ 11) Date of Next Appointment: _____

12) Have you had previous workers compensation injuries? ☐ Yes ☐ No If Yes, please enter dates of injuries and the body parts injured.

By affixing my signature, I attest that all information on this form is accurate and true.

Signature: _____ Date: _____