

## The Supervisors First Report of Injury Electronic Intake (FRI) Form

UTHealth Houston uses the [Supervisors First Report of Injury](#) to track workplace injuries and mishaps for all UTHealth Houston Employees (Faculty, Staff, UTP, HCPC, and Dunn), Residents, and Students.

- If you receive a paycheck through UTHealth Houston payroll, you are an employee, and if you sustain an injury while on the job, you must fill this out.
- This also applies to all Medical Residents and Students.
- Visitors may use this form and will be directed to the appropriate place.

This confidential report goes to the employee's supervisor, the Employee Health Clinic, and the Office of Risk Management and Insurance (RMI). If you have questions or concerns, call RMI at 713-500-8127 or 8100. This old PDF version of this form must be printed, filled out, signed by the supervisor and the employee, scanned, and then faxed to RMI. The institution is moving from the printed (paper) version to a new online electronic version.

The NEW online version can be found in the following locations as of December 9, 2024.

- [UT Health Services](#) (UTHS) Clinic [Employee Health Intranet](#).
- [Risk Management Home](#)
- [Occupational Health Program](#)
- From the below QR Code (Scan with your smartphone camera)



- The UTHealth Houston Notice To Employee Important Safety Information. Pages 10 and 12.

**You are an employee who has sustained an injury at work.** What do you do in addition to filling out the SFRI?

- For severe injuries that need immediate treatment, call 911 or go directly to the Emergency Department.
- **Employees and Residents:** For minor injuries, needle sticks, or other bloodborne pathogen (BBP) exposures, call the UTHS clinic at 713-500-3267. They will triage the injury and have you visit the clinic or re-direct you.
  - Hours are Monday – Friday, 7 AM – 4 PM. Located at 6410 Fannin St., Suite 100.
  - After hours, call the Needle Stick hotline at 800-770-9206.
- **Students:** For minor injuries, needle sticks, or other bloodborne pathogen (BBP) exposures, call the Student Health Clinic at 713-500-5171.
  - Hours are Monday – Friday, 8:30 AM – 5 PM. Located at 6410 Fannin St., Suite 130.
  - After hours, call 713-500-6824
- If you have a [Bloodborne Pathogen Exposure](#) link for more information.

## Reporting your workplace injury.

Click on a convenient link that will take you to the electronic [Work Injury Intake Form, also known as the Supervisor's First Report of Injury.](#)

### Overview

- **Step one:** Complete and submit the form. Please be thorough in your report.
- **Step two:** You will receive a document via your email from DocuSign allowing you to review your submission and sign the form. This will also route it to your supervisor so they can sign the form.
  - You may use your work email or your personal email. Both will allow you to review and sign the document. Institutional preference is that you use your work email.
- All submissions are in a HIPAA-compliant platform and are confidential. The information goes to:
  - Your direct supervisor, who must be alerted to your injury
  - Employee health for bloodborne pathogen (BBP) exposures
  - Risk Management for workers' compensation
  - Your email, allowing you to keep a record of your injury

1. The initial screen you see will look like the one below.

## Supervisor's First Report of Injury

In the event of an exposure, needlestick, or work injury please complete the form below. If this is a life threatening or medical emergency, please call 911 or report to the nearest emergency room

- **STEP 1: Complete and submit the first report of injury form below**
- **STEP 2: Upon completion of this form, a document for e-signing will be sent via docuSign/smartsheet to the emails provided on the form for final review and signatures**

**CONFIDENTIALITY STATEMENT:** UTHealth Houston requires you to provide personal health information protected by University policy and State and Federal law. Your information will be used or disclosed in accordance with those policies and laws only to the minimal extent necessary for your treatment or for business operations. Your rights to the confidentiality of your personal health information will be strictly maintained by UTHealth.

**Classification Type \***

- Employee/Staff/Faculty (must receive a check through UT payroll)
- Resident/Fellow (must receive a check through UT payroll)

1. Employee Classification is essential. This will ensure that the correct forms are filled out for the injured party.

**Classification Type \***

- Employee/Staff/Faculty (must receive a check through UT payroll)
- Resident/Fellow (must receive a check through UT payroll)
- Visiting Resident/Visiting Fellow/Visiting Student/Other Visitor
- Contract Worker
- Student

- If you choose Employee / Staff / Faculty, further categories of UTP, DUNN, HCPC, or UTHealth Houston Faculty or Staff will be asked.
- Visitors and Contract Workers are directed to forms that are appropriate to them.

2. The next step is to fill out the specific questions that follow the original format. You will need your supervisor's name, email, and phone number. If you only have their name, the form has a clickable [People Directory](#) for your convenience.

3. The form requires your name, email, and date of birth. You may use your personal email or your work email. It also asks for your employee ID. If you don't know your ID, leave this blank. You may find your employee ID on your timecard or your payroll check statement.

4. You will be asked the date, time, and location of the injury. And for the name of any witnesses.

**Accident Location \***

- **BE AS SPECIFIC AS POSSIBLE**
- What physical or work **address** did this injury occur? (**Building name, street, floor, room, specific stairwells...etc**)
- If your injury occurred **outside** please also include nearby roads or intersections

6410 Fannin Suite 100

5. You can free text a detailed description of the injury. Details are great to have in this area.

**Detailed Description of Reported Injury \***

Please provide a detailed description of the reported injury. (Mechanism of injury, how and what exactly happened)

6. The type of injury will be asked. You may only pick one type. Lacerations from a medical device or scalpel that are NOT clean should use a Needle stick/ Bloodborne pathogen injury type.

**Type of Injury \***

- Needlestick/Bloodborne Pathogen Exposure(contaminated scalpel, blade, bodily fluid splash..etc)
- Environmental Injury or Exposure (chemical spill/splash, chemical inhalation, work allergens..etc)
- Fall/Slip/Trip
- Burn
- Contusion/Bruise
- Bite
- Laceration/Cut (clean)
- Assault
- Eye Injury
- Allergic Reaction
- Other-(describe in description of injury box further below)

7. Additional information will pop up for your convenience if you have any injury that may result in a BBP exposure.

**NOTE FOR POSSIBLE BLOODBORNE PATHOGEN EXPOSURES**

**For guidance or questions regarding any immediate care, collecting source patient labs and reporting at the facility where your injury occurred, it is advised that you call the appropriate hotline or clinic.**

**DURING NORMAL BUSINESS HOURS:**

**Employee:** UTHealth Services 713-500-3267  
M-F 7-4p

**Student:** Student health 713-500-5171  
M-F 8:30a-5p

**AFTER HOURS HOTLINE NUMBERS:**

**Employee:** 800-770-9206

**Student:** 713-500-6824

24-hr answering service will ensure exposure coordinator calls back promptly.

**Calling DOES NOT account for formally reporting your injury.  
THIS FORM MUST STILL BE COMPLETED.**

8. Body Part affected – check all that apply. For example, if you fell from a ladder onto your right side, you might check back, right shoulder, right leg or knee, and right ankle or foot.

**Body Part Affected \***

- Head     Face     Neck     Chest     Abdomen  
 Back (Lower or Upper)     Left Eye     Right Eye  
 Left Shoulder     Right Shoulder     Left arm or hand  
 Right arm or hand     Left leg or knee     Right leg or knee  
 Left ankle or foot     Right ankle or foot     Left Toe(s)  
 Right Toe(s)     Other (describe in brief description of injury box below)

 **Body Part Affected must be checked to continue**

9. BBP exposure injuries will also request the source patient's unique identifiers.

**Source Patient Unique Identifiers \***

**Provide source patient name, date of birth, and MRN.** This information will assist in attaining source patient labs if possible.

If unknown, write unknown.

unknown

10. Indicate if you have lost or missed at least one full day of work due to the injury.

**Have you lost or missed at least one full day of work due to your injury? \***

- Yes, one full day or more  
 No

11. **In the case that the work injury requires you to leave or miss work, please choose an option below regarding taking paid leave or leave without pay:\***

If you have an on-the-job injury covered by workers' compensation insurance and are unable to work because of the injury, The University of Texas System will allow you to remain on the payroll by using all paid leave available to you.

**If you choose to use paid leave,** you must first use all available sick leave. Once all sick leave has been used, you may then choose to use one or more days of other paid leave in lieu of receiving temporary income benefits (TIBs). If you are still unable to work after using all paid leave, you will be removed from the payroll, and TIBs may begin.

**I do not wish to use leave,** or no leave is available; please be advised. That temporary income benefits (TIBs) will begin following the statutory seven-day waiting period if you have not been released to return to work. Employees are responsible for their Health Insurance Premiums after being in an unpaid position for more than 1 calendar month. Contact HR/Benefits regarding Health Ins.

Choose only ONE election, either Option 1 OR Option 2 below:

- Option 1- Paid Leave, When I lose time from work due to this injury or illness, I elect to use all accrued sick leave to remain on the payroll
- Option 2- Leave without pay, I do not wish to use leave, or no leave is available

**Leave without pay acknowledgment \***

- I understand temporary income benefits will begin following the statutory 7 day waiting period if I have not been released to return to work and I am responsible for my health insurance premium after being on unpaid leave for more than 1 month

12. If you choose Paid Leave, you will be asked how many hours of your other leave you want to use once your sick leave is exhausted.

**Once sick leave has exhausted, choose one of A, B, or C below: \***

- A. All of my other available leave
- B. A portion of my other available leave
- C. None of my other available leave

**Option B continued: \***

I wish to use \_\_\_\_\_ hours of my *other* available leave

16

13. Final Steps: Date and submit.

**Date Today \***

09/12/2024



Next Actions after submitting:

**You will receive an email for signing from DOCUSIGN. Please complete ASAP for processing.**

**For any non-medical or general questions:**

Risk Management/Workers' Comp at firstreportofinjury@uth.tmc.edu  
713-500-8127 or the main line at 713-500-8100

**All other questions:**

UTHealth Services Employee Health:  
713-500-3267 -phone.  
Occupational.health@uth.tmc.edu -email

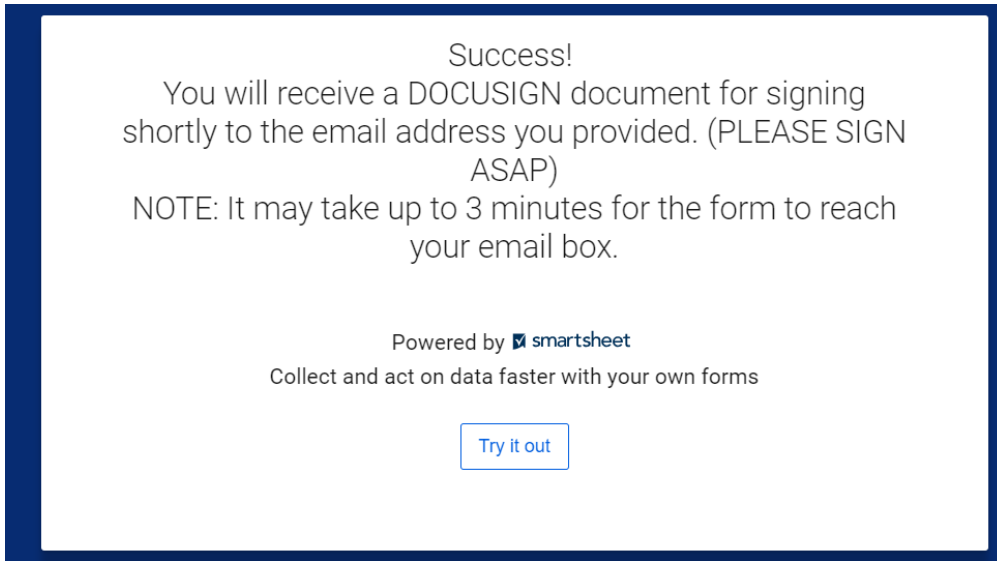
UT HCPC/DUNN  
713-741-3897-phone  
Deborah.Parker@uth.tmc.edu

UT Student Health:  
Phone number: 713-500-5171  
6410 Fannin St. Suite 130  
ms.studenthealthclinic@uth.tmc.edu

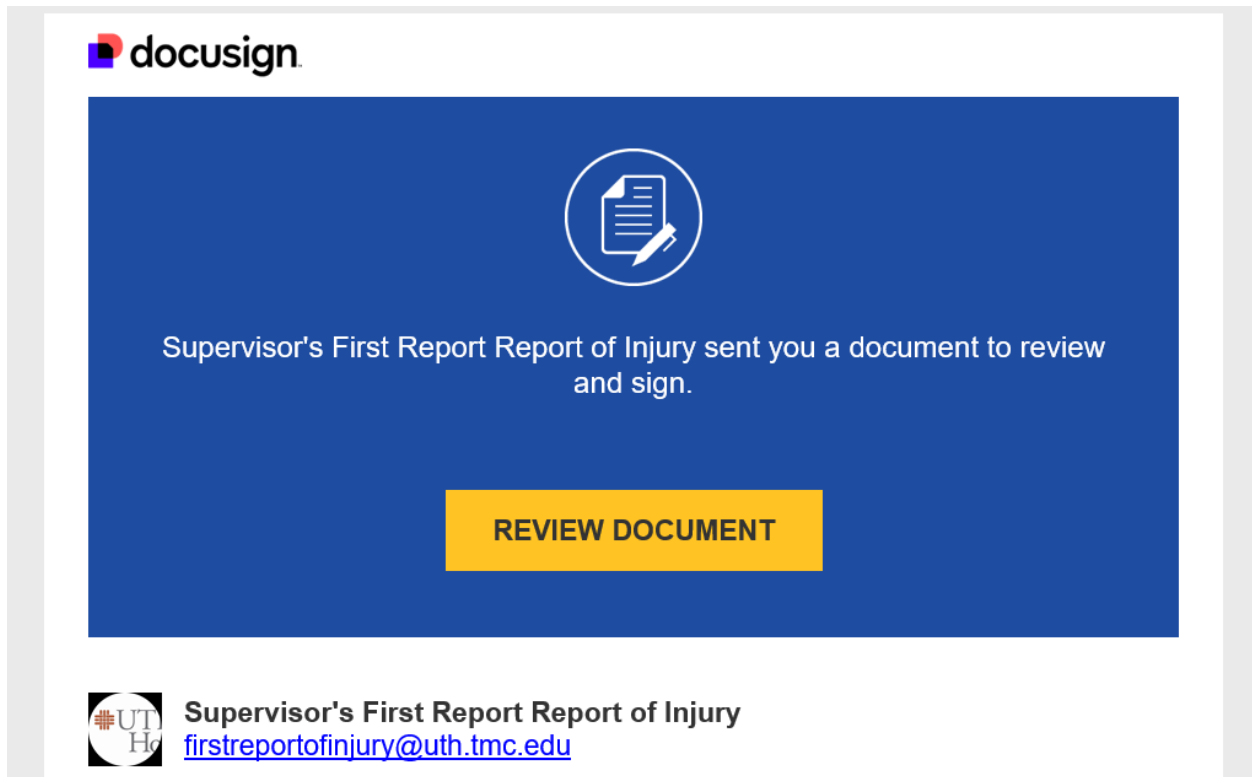


Submit

14. After submitting, you will receive a SUCCESS message indicating the form is complete and being routed to your email for signatures.




15. The email will appear as below – asking you to review the Supervisors First Report of Injury. Please complete the DocuSign. This will then route the FRI to the appropriate supervisor, Employee Health, and to the Office of Risk Management and Insurance.




16. Once you open the document to review you will need to agree to the use of electronic records and signatures. Hit continue to move forward.

This site uses cookies, some of which are required for the operation of the site. [Learn More](#) OK

### Please Review & Act on These Documents

 **Supervisor's First Report Report of Injury**  
UTHealth - Master Account

Review the document, sign, and then submit.  
After signing, it will be processed directly to the UTHealth EHS/Risk Management/Workers' Comp department.  
[View More](#)



Please read the [Electronic Record and Signature Disclosure](#).

I agree to use electronic records and signatures. CONTINUE OTHER ACTIONS ▾

Supervisor Notified: 09/12/24 Telephone: 7135003258  
Witness: Doy Harrison  
Put Accident Location Here: 6410 Fannin Suite 100  
Building Name, Street, City, County, State, Zip Location (ex: Floor/Room #, Hall, Classroom)  
Body Part Affected: Left arm or hand Injury Type: Needlestick/Bloodborne Pathogen Exposure(contaminated scalpel, blade, bodily fluid splash..etc)  
Left Pointer (index) finger



17. You can review the document for the accuracy of the work injury description.



ID# [redacted] TITLE: Professor INJURY DATE: 09/12/24 Time of Injury: 10:00 AM  
Name: [redacted] TELEPHONE: 700-221-500  
HOME ADDRESS: [redacted]  
Date of Birth: 09/01/88 SEX: Female  
SUPERVISOR, Attending Physician: [redacted] Time supervisor notified: 10:15 AM EMPLOYEE/RESIDENT/STUDENT: Employee/Staff/Faculty (must receive a check through UT payroll)  
Supervisor Notified: 09/12/24 Telephone: 7135003258  
Witness: [redacted]  
Put Accident Location Here: 6410 Fannin Suite 100  
Building Name, Street, City, County, State, Zip Location (ex: Floor/Room #, Hall, Classroom)  
Body Part Affected: Left arm or hand Injury Type: Needlestick/Bloodborne Pathogen Exposure(contaminated scalpel, blade, bodily fluid splash..etc)  
Left Pointer (index) finger  
Provide Brief Description of Reported Injury:  
Cleaning a room after a procedure and received a needle stick from a syringe that was not put in the correct place.





18. There are three areas that you need to initial and two areas for signature.



Cleaning a room after a procedure and received a needle stick from a syringe that was not put in the correct place.



Employee/Resident has been offered medical attention but does not wish to receive any at this time. This does not prevent you from seeking medical attention at a later date. (A) (Initial here)  

Employee/Resident has received a copy of the Business Procedures Memorandum (BPM) 66-10-04 concerning confidentiality of your social security number. (see pg 6) (B) (Initial here)  

Employee/Resident has signed Acknowledgement Form (see pg 2) & received Notice of Network Requirement Packet. (Students do not sign the Acknowledgement Form) (C) (Initial here)  

**INFORMATION RELEASE**  
I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me, or my health, to furnish to the U.T. System, Office of Risk Management or its representative any and all information relevant to the injury or illness which I am reporting, including: medical history, consultation reports, hospital records, etc. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature of Injured Party for information release:   Date: 9/12/2024

  9/12/2024

Signature of Injured Party Date Signature of Supervisor, Attending or Director Date

19. You will need to adopt a signature style in DocuSign.

**Adopt Your Signature**

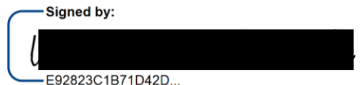

Confirm your name, initials, and signature.

\* Required


Full Name\*  Initials\*

[SELECT STYLE](#) [DRAW](#) [UPLOAD](#)

**PREVIEW** [Change Style](#)

Signed by:  Initial   
E92823C1B71D42D...

By selecting Adopt and Sign, I agree that the signature and initials will be the electronic representation of my signature and initials for all purposes when I (or my agent) use them on documents, including legally binding contracts.

 [ADOPT AND SIGN](#) [CANCEL](#)

20. The second section requiring your signature is Workers' Compensation Network Acknowledgement Form. This informs you how to get health care under workers' compensation insurance.

Name of Carrier: The University of Texas System Name of Network: IMO Med-Select Network\*


Home Address:    
Street Address – No P.O. Box or Work Address

---

City	State	Zip Code	County
<input type="text" value="[Redacted]"/>	<input type="text" value="09/12/24"/>	<input type="text" value="700-221-500"/>	<input type="text" value=""/>

Printed Name:  Date of Injury:  Employee Phone Number:

Employee Signature:  Date:



For more information please contact the Office of Safety, Health, Environment & Risk Management at (713) 500-8100 or 8127

When you receive the fully completed form, a printed section will outline the information below.

### Workers' Compensation Network Acknowledgement Form

I have received the Notice of Network Requirements which informs me how to get health care under workers' compensation insurance.

If I am hurt on the job and live in the service area described in this information, I understand that:

1. I must choose a treating doctor from the list of physicians in the IMO Med-Select Network Or, I may ask my HMO primary care physician to agree to serve as my treating doctor by completing the Selection of HMO Primary Care Physician as Workers' Compensation Treating Doctor Form # IMO MSN-5.
2. I must go to my network treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
3. The insurance carrier will pay the treating doctor and other network providers.
4. I may have to pay the bill if I get health care from someone other than a network doctor without network approval.
5. If I receive the Notice of Network Requirements and refuse to sign the Acknowledgement Form, I am still required to use the network.

21. The 3<sup>rd</sup> area requiring a signature is your election of leave.

6. A portion of my other available leave  I wish to use  of my other available leave.

**Timekeeper/Supervisor complete this section**

EMPLOYEE LEAVE BALANCE AS OF: \_\_/\_\_/\_\_\_\_ (MM/DD/YYYY)  
Sick Leave: \_\_\_\_\_ hours Other Leave\*: \_\_\_\_\_ hours (Include Vacation, Compensatory, Other)

- The first full workday covered by sick or other leave balance is \_\_/\_\_/\_\_\_\_
- Leave Exhaustion Dates:
  - The last full workday covered by employee's sick leave balance is \_\_/\_\_/\_\_\_\_  
(Calculate and enter the last full workday that sick leave will cover based on current total balance)
  - The last full workday covered by employee's other leave election is \_\_/\_\_/\_\_\_\_
  - Leave without pay date is \_\_/\_\_/\_\_\_\_ (The same date as the first unpaid leave date on the employee's paycheck)

By signing below, I understand that I may not change my sick leave election once submitted. Once sick leave is exhausted, I may use all or a portion of other available leave before being placed on TIBs.

Employee or Employee Representative Signature  Date: 9/12/2024

Fax or Email a Copy to: Risk Management & Insurance, OCB 1.330, (713) 500-8127, (Fax) 8111, [sondra.k.faul@uth.tmc.edu](mailto:sondra.k.faul@uth.tmc.edu)  
Original: Home Department Maintains

WCI Form-23  
Revised 12/2022

22. After all areas requiring a signature have been completed you will need to select the FINISH button to complete all actions.

This site uses cookies, some of which are required for the operation of the site. [Learn More](#)

one! Select Finish to send the completed document.

UTHealth Houston SUPERVISOR'S FIRST REPORT OF INJURY

ID#  TITLE:  INJURY DATE:  Time of Injury:   
Name:  TELEPHONE:

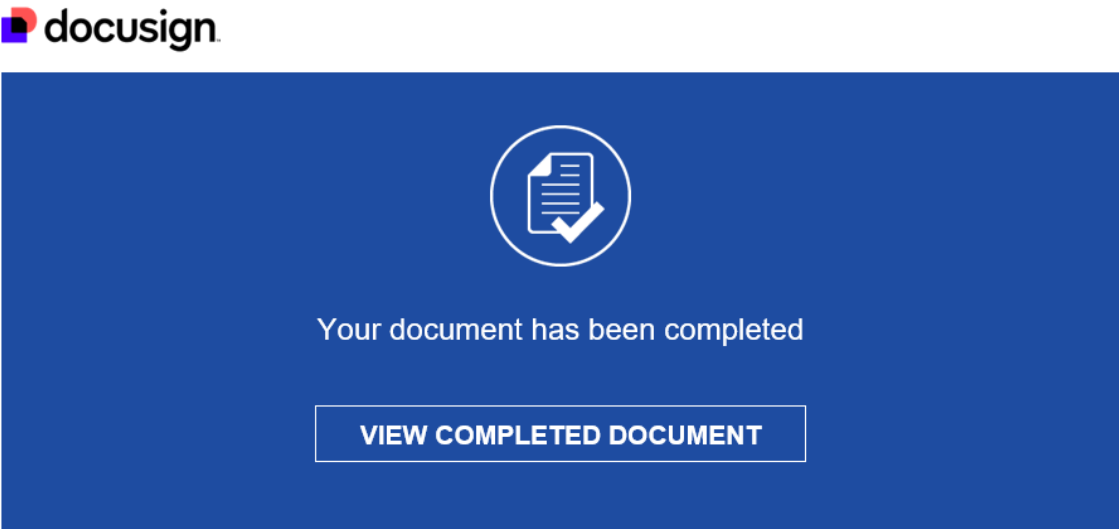
23. The box below will pop up when you have completed signing the document. You are welcome to print at this time or wait for the document to come to your email.

**You're Done Signing**


A copy of this document will be sent to your email address when completed by all signers. You can also download or print using the icons above.

To learn more about signing, click [here](#).

24. You can then view the completed document and save it as a PDF when you receive a complete document in your email.

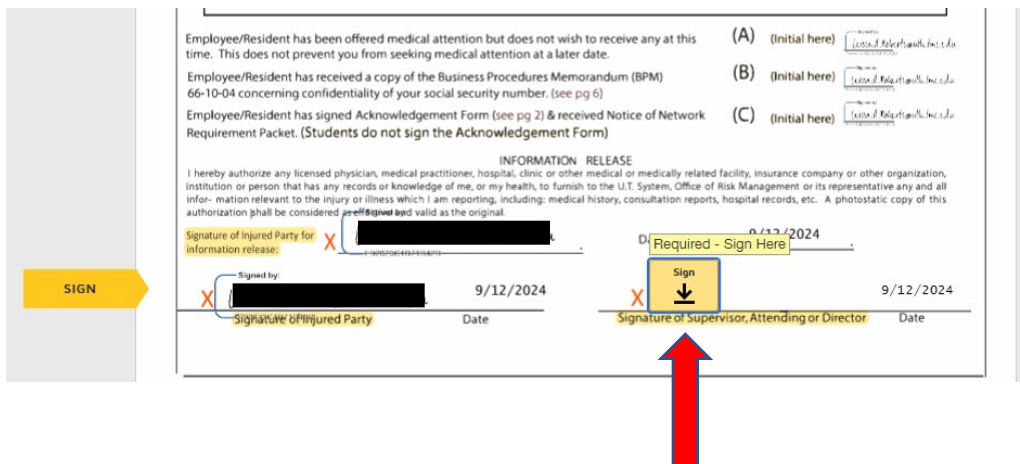


The banner features the Docusign logo at the top left. In the center, there is a white circular icon containing a document with a checkmark. Below the icon, the text reads "Your document has been completed". At the bottom center, there is a white rectangular button with the text "VIEW COMPLETED DOCUMENT".

 **Supervisor's First Report Report of Injury**  
[firstreportofinjury@uth.tmc.edu](mailto:firstreportofinjury@uth.tmc.edu)

### Supervisors:

If you are a supervisor, you will receive an email alerting you to the injury, and your signature is required on the document.



The form contains several sections. At the top, there are three rows of text with checkboxes (A, B, and C) and corresponding signature lines. Below this is an "INFORMATION RELEASE" section with a paragraph of text. At the bottom, there are two signature lines. The first line is for the "Signature of Injured Party for information release" and is marked with an 'X'. The second line is for the "Signature of Supervisor, Attending or Director" and is marked with an 'X'. A yellow box with the text "Required - Sign Here" is placed over the supervisor's signature line. A red arrow points to this box. To the left of the form, there is a grey vertical bar with a yellow arrow pointing right and the word "SIGN" in black text.