**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.

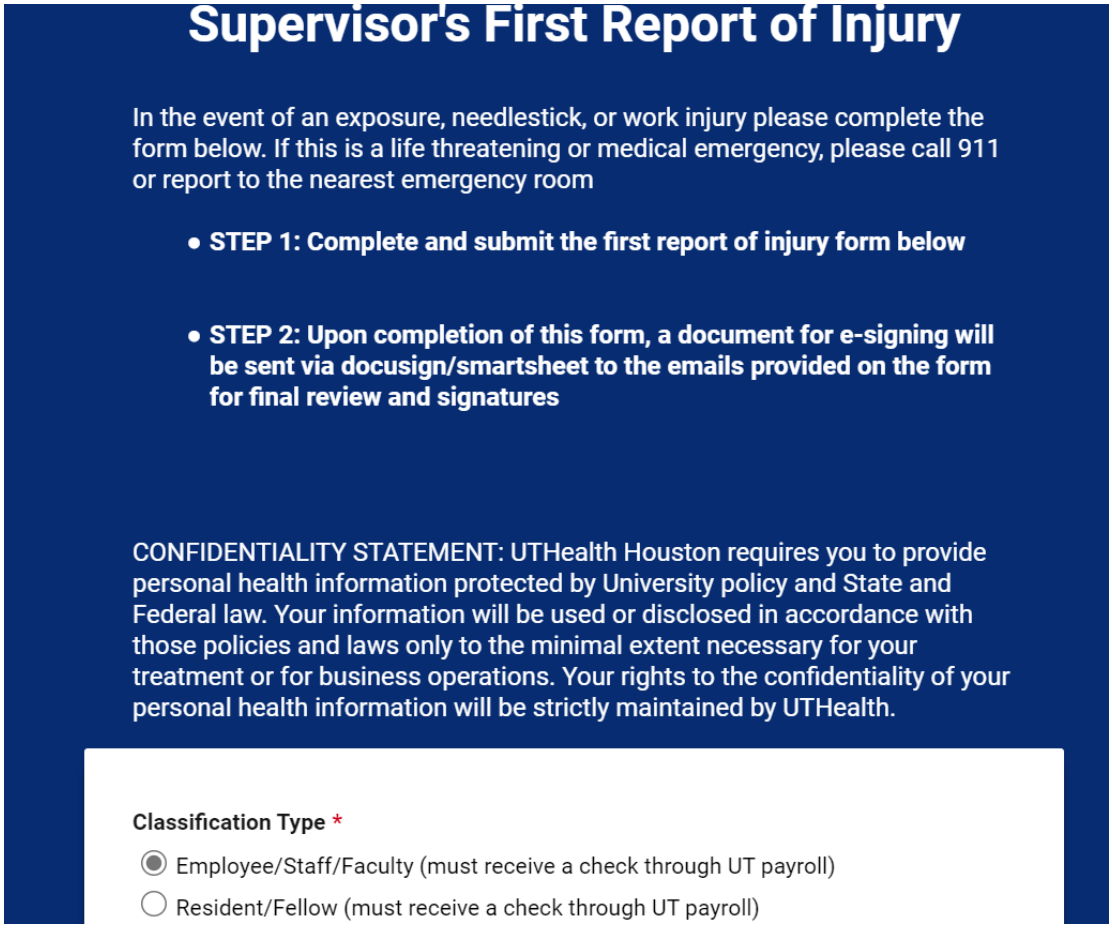
## Reporting your workplace injury.

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.



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 of 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

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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:**

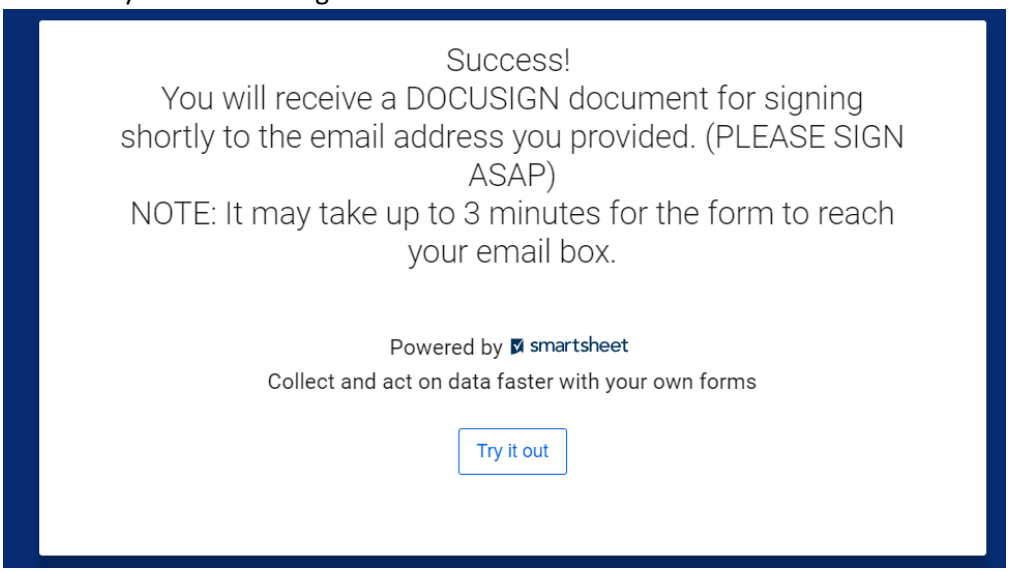
UTHealth Services Employee Health:
713-500-3267 -phone.
Occupational.health@uth.tmc.edu -email

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

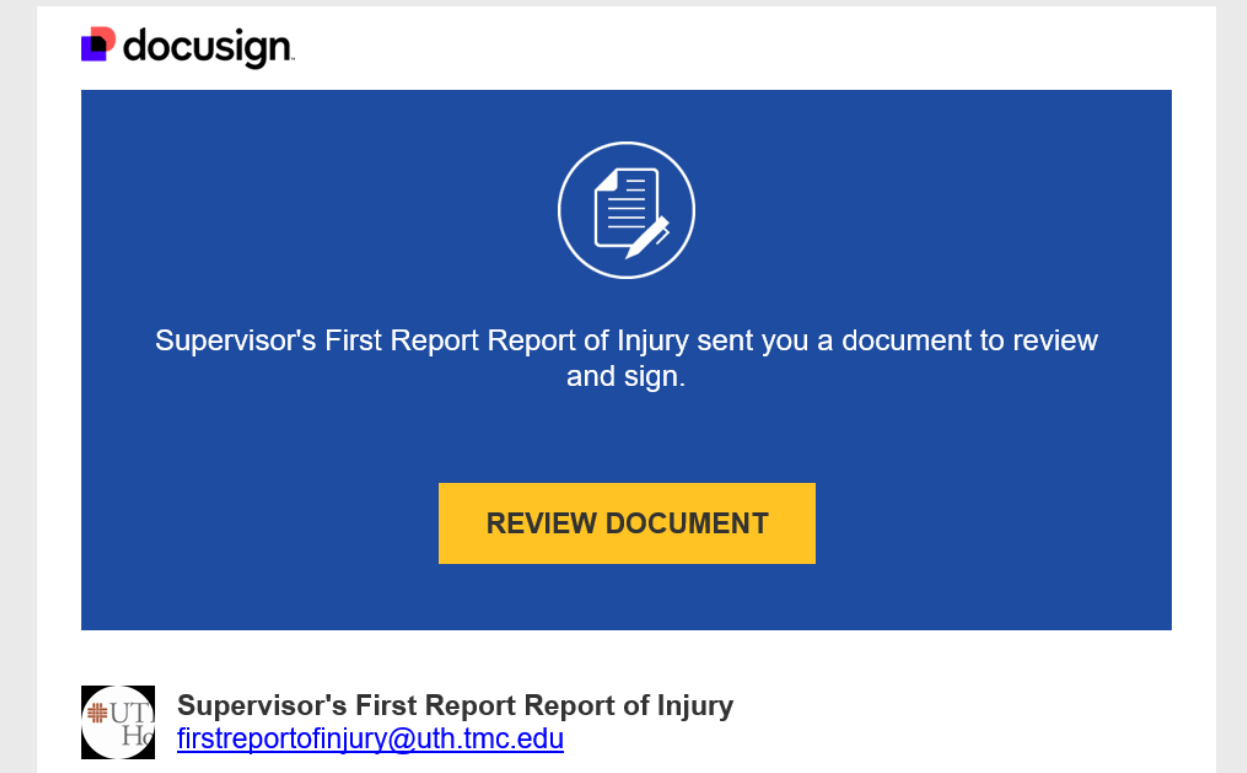
UT Student Health:
Phone number: 713-500-5171
6410 Fannin St. Suite 130
ms.studenthealthclinic@uth.tmc.edu

Submit

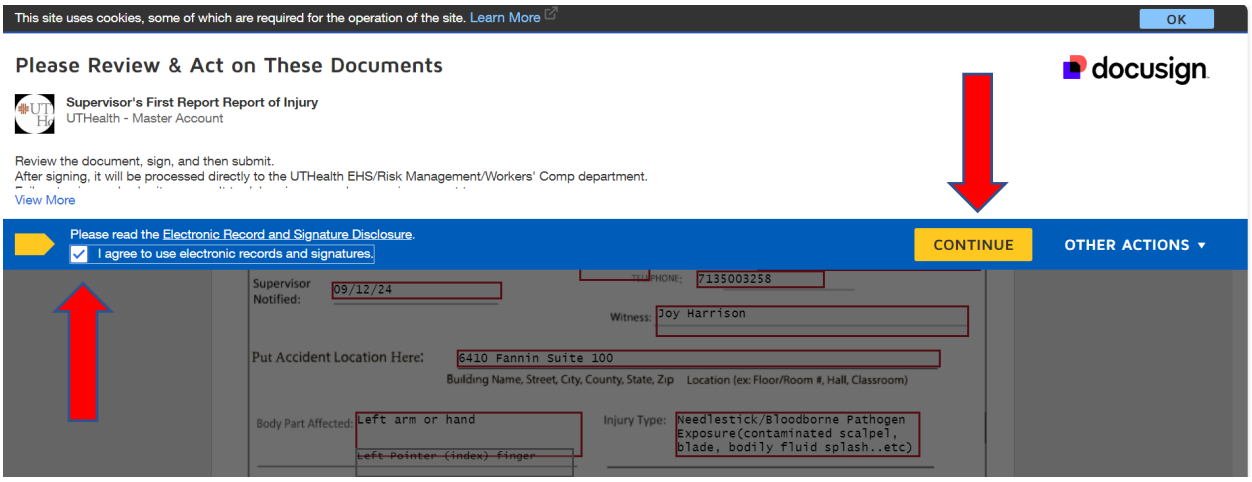
14. After submitting, you will receive a SUCCESS message indicating the form is complete and being routed to your email for signatures.



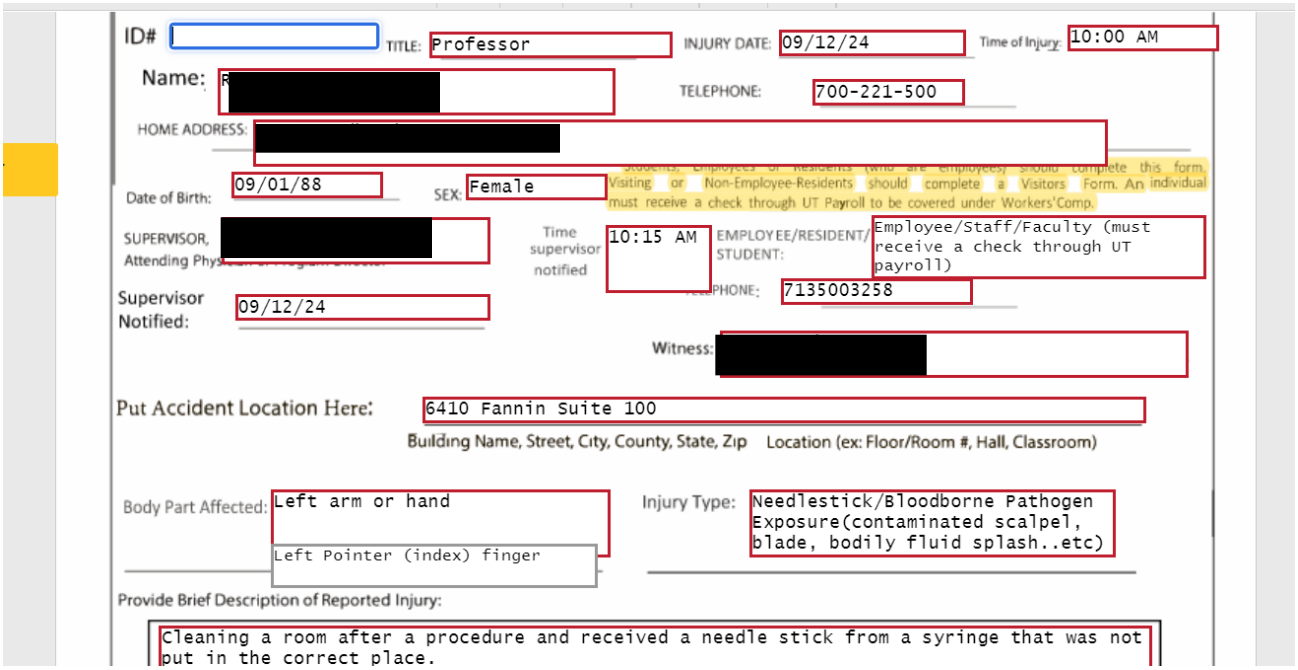

15. The email will appear as below – asking you to review the Supervisors First Report of Injury. Please complete the DocuSign. This will then route the FRI to the appropriate supervisor, Employee Health, and to the Office of Risk Management and Insurance.



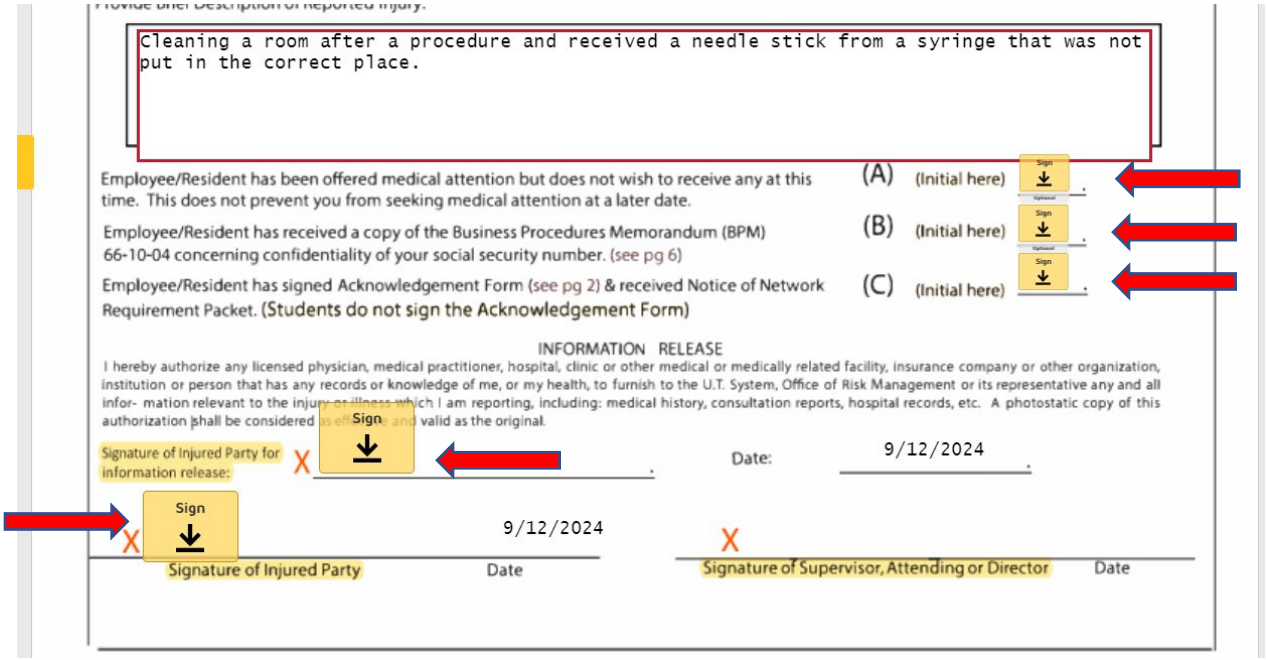
16. Once you open the document to review you will need to agree to the use of electronic records and signatures. Hit continue to move forward.



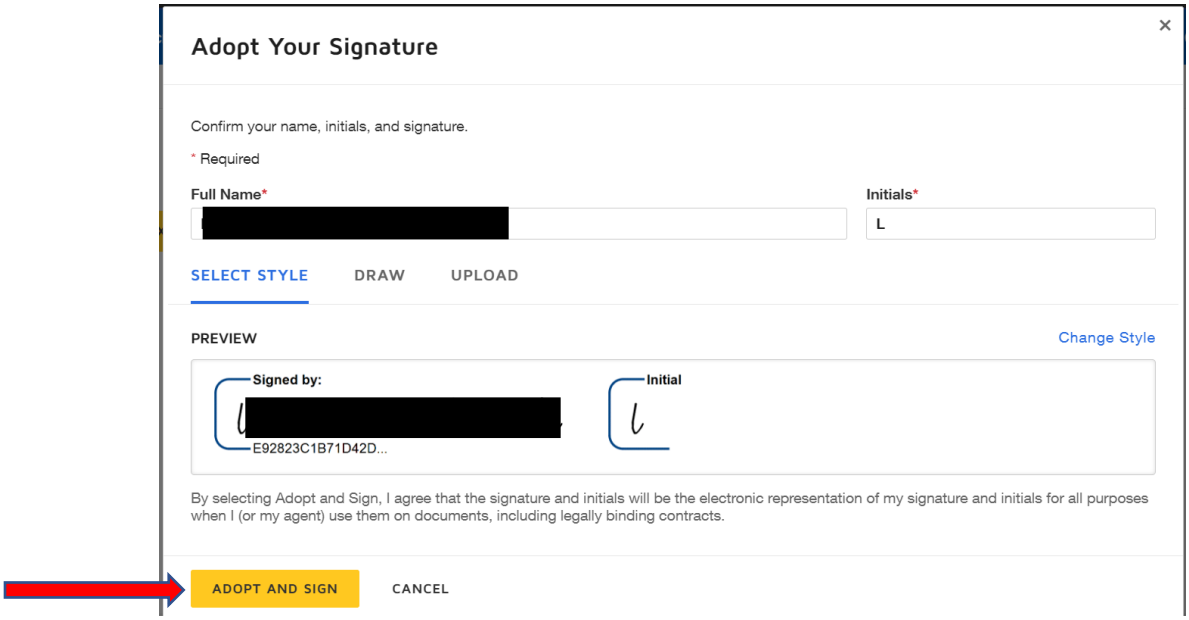

17. You can review the document for the accuracy of the work injury description.



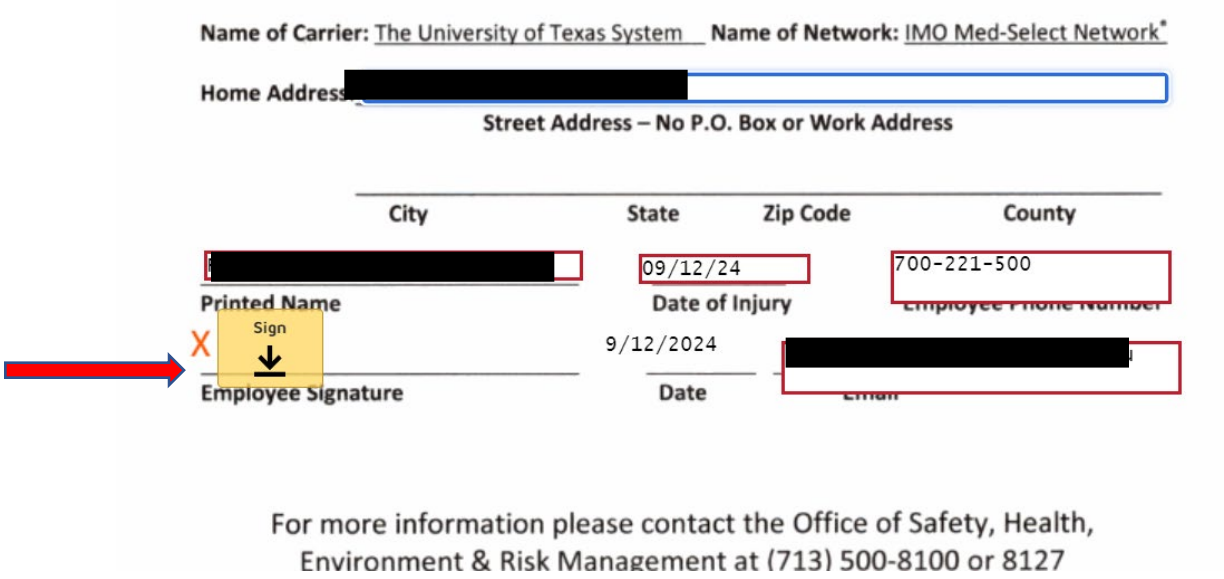
18. There are three areas that you need to initial and two areas for signature.




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



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.




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

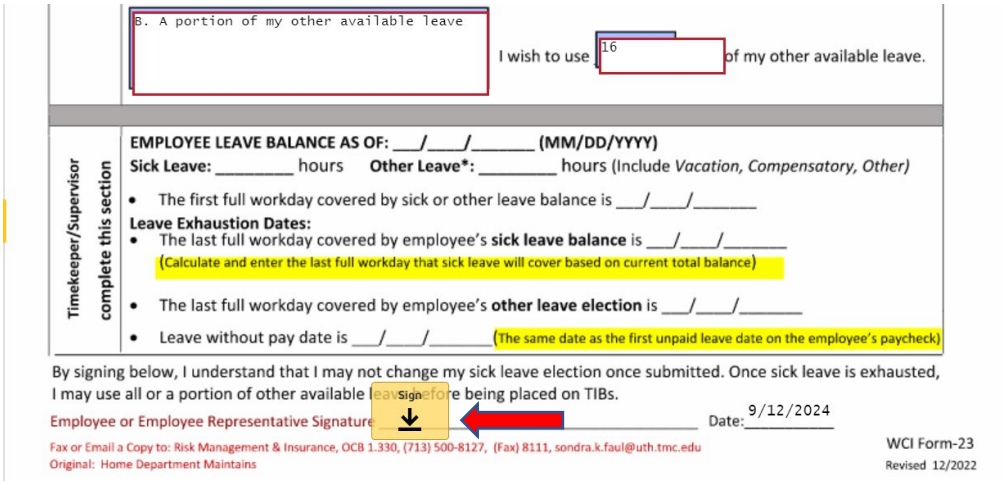
## Workers' Compensation Network Acknowledgement Form

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

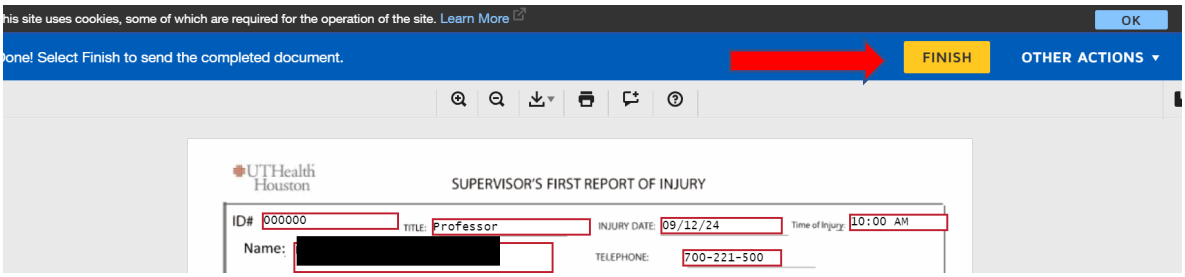
If I am hurt on the job and live in the service area described in this information, I understand that:

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.

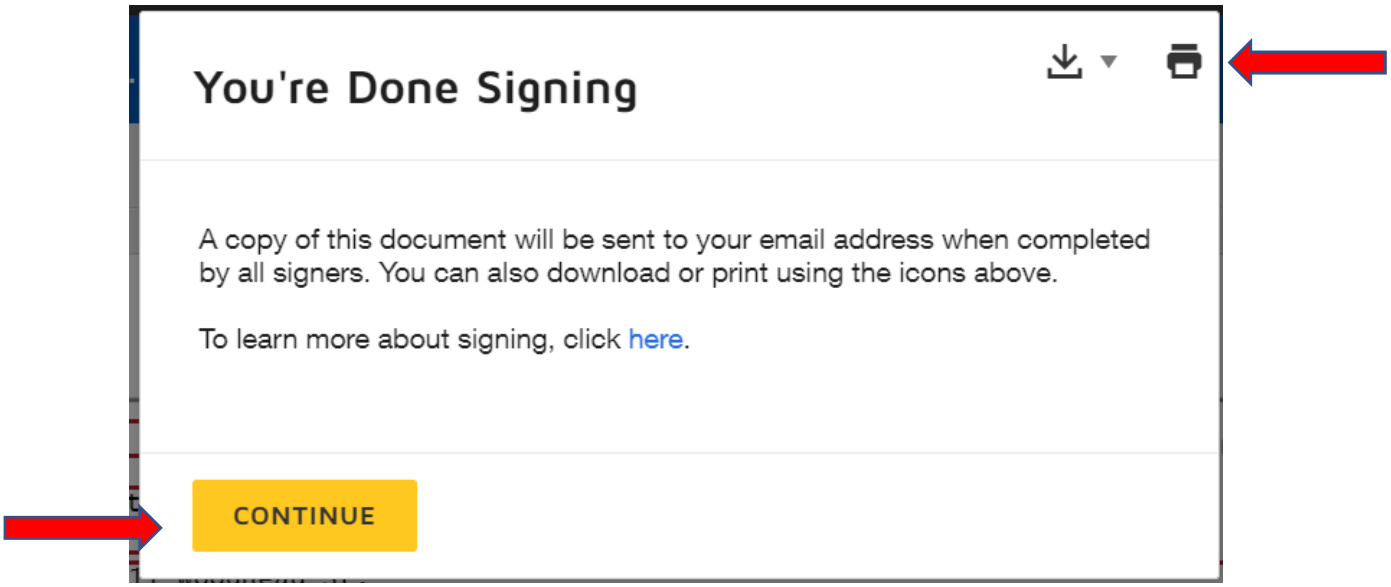
21. The 3rd area requiring a signature is your election of leave.



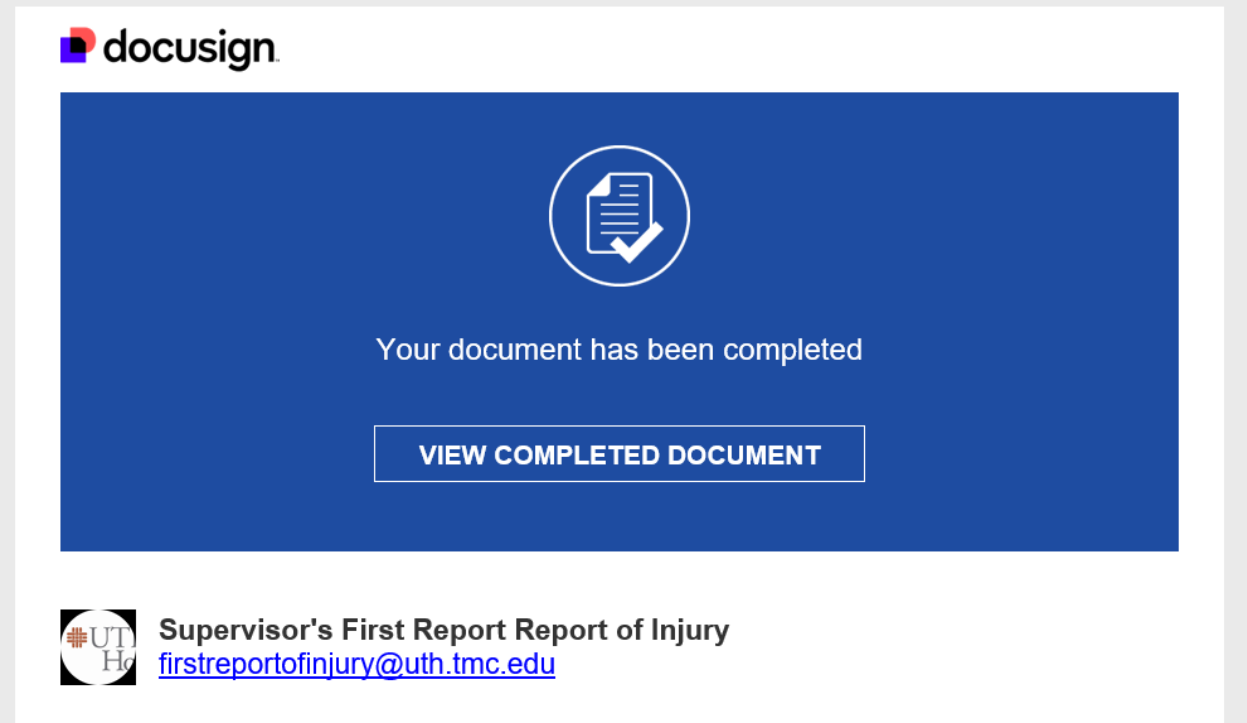

22. After all areas requiring a signature have been completed you will need to select the FINISH button to complete all actions.




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.



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




## Supervisors:

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