UTHealth
The University of Texas Health Science Center at Houston

SUPERVISOR'S FIRST REPORT OF INJURY

All Fillable Form versions must be printed and submitted with original signatures.

See instruction sheet

ID# _____ TITLE: _____ INJURY DATE: ____/____/____ (Month / Day / Year) Time of Injury: ☐ AM ☐ PM

NAME: _____ (Last / First / MI) TELEPHONE: ( ) _____ (Work #) ( ) _____ (Home/Cell#)

HOME ADDRESS: _____ (Street or Box / Apt# / County / City / State / Zip Code)

Date of Birth: ____/____/____ (Month / Day / Year) SEX: ☐ Male ☐ Female

**Students, Employees or Residents (who are employees) should complete this form. Visiting or Non-Employee-Residents should complete a Visitors Form. **An individual must receive a check through UT Payroll to be covered under Workers' Comp.

DEPARTMENT: _____ INTEROFFICE ADDRESS: _____ EMPLOYEE/RESIDENT ____ STUDENT ____

SUPERVISOR, Attending Physician or Program Director _____ TELEPHONE: ( ) _____ (Work # / Cell/Pager#)

Date Supervisor Notified: ____/____/____ (Month / Day / Year) _____ Time ☐ AM ☐ PM Witness: _____

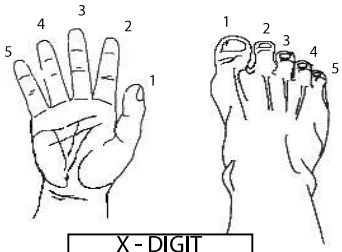
MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Widow _____ Full Name of Spouse

Put Accident Location Here:

Building Name, Street, City, County, State, Zip Location (ex: Floor/Room #, Hall, Classroom)

BODY PART AFFECTED	X	Left or Right

Check Appropriately		Check Appropriately	L	R
Head		Eye		
Face		Shoulder		
Neck		Arm or Hand		
Chest		Leg or Knee		
Stomach		Ankle or Foot		
Back(Lower or Upper)		Toe		
Oth-		Other		



X - DIGIT

1	2	3	4	5
1	2	3	4	5

INJURY TYPE	
Check Appropriately	
Fall	
Needle Stick***Click for protocol	
Exposure***Click for protocol	
Sprain / Strain	
Burn	
Contusion / Bruise	
Bite**Describe Source Below	
Laceration / Cut	
Assault or Accident	
Eye Injury	
Other-Describe Below	
Rash	

Provide Brief Description of Reported Injury: _____

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) _____

_____ Signature of Injured Party Date

_____ Signature of Supervisor, Attending or Director Date

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: _____ Date: _____

ALL INFORMATION MUST BE COMPLETED BEFORE REPORT CAN BE PROCESSED

Distribution:
- Fax a copy to: Risk Management & Insurance, Phone: (713) 500-8127 or 8100, Fax (713) 500-8111
- BSC Employees should contact their supervisor or the supervisor on duty to report their injury.
- Maintain a copy for department files *

Students are not covered under Workers' Compensation, this form is for record only.

WCI - 05/02/24

***Needlestick/BBP/TB Exposure: Students Hotline# 713-500-OUCH, Employee/Resident Hotline# 713-500-3267 ext 1 or 800-770-9206

Instructions for Supervisor's First Report of Injury

1. Report work injury/illness to your supervisor. If this is a Needlestick/Bloodborne Pathogens or TB Exposures; **please refer to the protocol sheet and call the appropriate hotline.**

2. **Employee/Resident/Student** need to complete and sign the **Supervisor's First Report of Injury ("FRI")**; including the Information Release section. **Employees/Residents** need to complete & sign the **Network Acknowledgment Form. **Submit completed forms to RMI,do not send the entire packet. The remaining pages concerning the IMO network should be given to the UT Health Employee/UT Health Resident/Fellow. Non-Employee Residents should complete a Visitors Form.**

3. **Employee/Resident** if you choose not to seek medical attention initial **(A). {This does not prevent you from seeking care at a later date}.**

4. **Employee/Resident** initial **(B)** indicating that a copy of the Business Procedures Memorandum (BPM) 66-10-04 concerning confi dentiality of your social security number was received.

5. **Employee/Resident** initial **(C)** indicating that the Network Acknowledgement Form & the Notice of Network Requirement Packet have been received.

6. Have your **supervisor sign and date the form.** Your supervisor's signature acknowledges the work-related injury/illness was reported and the date the injury/illness was reported.

7. **Submit** the completed forms to **RMI** by fax (713-500-8111) or encrypted email (sondra.k.faul@uth.tmc.edu).

8. **Lost Time?** Call Risk Management & Insurance ("**RMI**")/Workers' Compensation (713) 500-8127 or 8100. A **Request for Paid Leave Form** must be completed and submitted to RMI within 3 days of lost time. This applies even if personal sick or vacation time is used.

IMO Information does not pertain to Students, Visiting Residents or Fellows.

Student should contact UT Student Health Services at 713-500-5171.

Visiting/Non-Employee Residents or Fellows should contact their employer.

9. As of **April 1, 2013**, UT System has contracted with IMO Med-Select, a certifi ed workers' compensation health care network, to provide medical care for UT Health employees who sustain work-related injuries/illnesses.

Non-Emergency Care: If you live within the IMO Med-Select network service area, you must seek medical care from an IMO Med-Select network provider. Your medical provider will refer you to a network specialist, if necessary. If you receive medical care from an out-of-network provider, you may be financially responsible for the services provided should it be determined that you live within the network service area. UT Health Employee/ UTHealth Residents can go to the IMO website at **www.injurymanagement.com** for a list of network providers.

For your convenience UTHealth Employees/Residents can be seen at UTHealth Service ("UTHS") which is part of the IMO health care network. UTHS is located at 6410 Fannin, UTPB 100. Please call 713-500-3267 ext 1 for treatment Take a copy of the Supervisor's First Report of Injury and Acknowledgement Form to the appointment. **Emergency Care:** In an emergency situation, you should seek medical care from the nearest hospital emergency room. However, follow-up medical care should be received from a network provider.

Out-of-Network Care: If you live outside of the IMO Med-Select network service area, you are not required to be treated by an IMO Med-Select network provider. You should seek medical care from any provider who accepts Workers' Compensation Insurance.

Note: Supervisor/Employer's failure to report lost days, return to work, resignations/terminations within (3) days of knowledge could result in fines up to $25,000.00 per day per occurrence issued by the Texas Department of Insurance-Divison of Workers' Compensation.

Please contact RMI (713-500-8127 or 713-500-8100) or visit the Safety, Health, Environment and Risk Management web page at https://www.uth.edu/safety/risk-management-and-insurance/.

STEPS TO BE TAKEN IN THE EVENT OF A NEEDLESTICK/ BLOODBORNE PATHOGEN OR TB EXPOSURE

Students

- Apply first aid:
  1. Clean exposed area with soap and water for at least 15 minutes.
  2. Flush mucous membranes with water or saline for at least 15 minutes.
- If the source patient is known and present, keep individual on-site for a blood draw (*see below)
- Notify instructor / clinic supervisor / hospital supervisor to report injury
- Obtain medical evaluation and treatment at:
  Student Health Services Clinic
  UTPB Suite 130
  713-500-5171
  Hours: M-F 8:30am – 5:00pm
- Call the Needlestick Hotline: 713-500-OUCH (if after hours the exposure coordinator will call you back shortly)
- Complete the '**UT Health** Supervisor's First Report of Injury Form' to document the injury and submit to Risk Management & Insurance Program at OCB 1.330 or fax 713-500-8111

* In the State of Texas, you have the right to the identification, documentation, testing, and results of the source individual infectious disease status. Arrangements should be made immediately with UT Student Health Services or the hospital where the incident takes place for testing the source individual. Source individual testing should include HIV antibody, Hepatitis C antibody, and Hepatitis B surface antigen.

UTHealth Employees, Faculty, or Residents

(you must receive a UT Health paycheck for these categories)

- Apply first aid:
  1. Clean exposed area with soap and water for at least 15 minutes.
  2. Flush mucous membranes with water or saline for at least 15 minutes.
- If the source patient is known and present, keep individual on-site for a blood draw (*see below)
- Notify clinic / supervisor / hospital supervisor to report injury
- Obtain medical evaluation and treatment at:
  UT Health Services Clinic
  UTPB Suite 100
  713-500-3267 (select Ext. 1)
  Hours: M-F 7:00am – 4:00pm
- If after hours, call the Needlestick Hotline: 800-770-9206 (24-hr answering service will ensure exposure coordinator calls back promptly)
- Complete the '**UT Health** Supervisor's First Report of Injury Form' to document the injury and submit to Risk Management & Insurance Program at OCB 1.330 or fax 713-500-8111

* In the State of Texas, you have the right to the identification, documentation, testing, and results of the source individual infectious disease status. Arrangements should be made immediately with UT Health Services or the hospital where the incident takes place for testing the source individual. UTP outlying clinics have been provided with exposure kits to draw source patient blood onsite. Source individual testing should include HIV antibody, Hepatitis C antibody, and Hepatitis B surface antigen.

04.07.22