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

DEPARTMENT: ______________ INTEROFFICE ADDRESS: ______________ EMPLOYEE ____ RESIDENT ____ *STUDENT ____
☐ Full Time ☐ Part Time (Check all that apply)

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

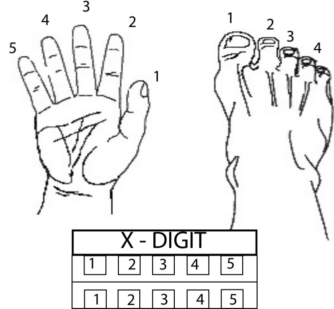
Accident Location:

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

BODY PART AFFECTED — X Left or Right

Check Appropriately	
Head	
Face	
Neck	
Chest	
Stomach	
Back(Lower or Upper)	
Oth-	

Check Appropriately	L	R
Eye		
Shoulder		
Arm or Hand		
Leg or Knee		
Ankle or Foot		
Toe		
Other		



INJURY TYPE	
Check Appropriately	
Fall	
Needle Stick***See protocol	
Exposure***See 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. .... (B) (Initial here) ________

Employee has signed Acknowledgement Form & received Notice of Network Requirement Packet. (Medical Foundation Residents and 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
- HCPC 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 - 09/12/18 ***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 only** 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.**

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 confidentiality of your social security number was received.

5. **Employee (only)** 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 or UT System Medical Foundation Residents. Students should contact UT Student Health Services at 713-500-5171.

Medical Foundation Residents should contact UT Health Service at 713-500-3267 x 1.

9. As of **April 1, 2013**, UT System has contracted with IMO Med-Select, a certified 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 resonsible for the services provided should it be determined that you live within the network service area. UT Health Employee can go to the IMO website at **www.injurymanagement.com** for a list of network providers.

For your convenience UT Health Employees can be seen at UT Health Service ("UTHS") which is part of the IMO health care network. UTHS is located at 7000 Fannin, UCT 1620. 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

If a Student	If a UTHealth Employee, Faculty, or Resident	If a UTPhysicians Insperity Employee
• 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 ‘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	• 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 UCT Suite 1620 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 ‘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	• 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 UCT Suite 1620 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 ‘First Report of Injury’ and Sharps Injury Log to document the injury and submit to Insperity.
* 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.	* 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.	* 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.