The University of Texas System

Employee's First Report of Work-Related Injury or Endemic Illness

Employee Information

Injured Employee's Name: _______________________________________ Male ( ) Female ( ) Date of Birth: ____/ ____/ ________

Home/Cell Phone: (_____) ______________ Work Phone: (_____) ______________ Preferred Language: ____________________

Personal Email Address: ______________________________ Work Email Address: ____

Home Address: ____City: _____________________ State: _______ Zip: __________

Married ( ) Single ( ) Widowed ( ) Spouse's Name: _________________ ( ) NA Number of dependent children? ______________

Employing Institution: _______________________ Job Title: ______________________________ Full Time ( ) / Part Time ( )

Department: __________________________________ State/Country of Hire: _____________ Country of Citizenship: _____________

Incident Information

City/Country/Location where occurrence happened (Please be specific) ____

Address/Description of location where occurrence happened (Please be specific)____

Date of occurrence: ____________ Time of occurrence: ______ ( ) AM ( ) PM Did you notify your supervisor? ( ) Yes ( ) No

Date Supervisor Notified: ________ Time _______ ( ) AM ( ) PM Name of Supervisor: ____________________________________

Were there any witnesses? ( ) Yes ( ) No Witness Name ____________________________ Phone: (_____) ______________

Did you seek medical treatment for this occurrence? ( ) Yes ( ) No If Yes, List name and address of hospital / physician below:

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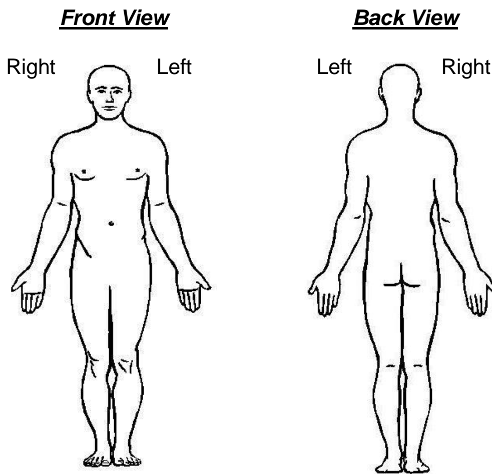
Were days lost from work due to occurrence(not including injury date)? ( ) Yes ( ) No Have you returned to work*?) Yes ( ) No

Date Returned to work*: ___/ ___/ _______ Trip Purpose/Work Performed: ____

***Return to work could include duties at UT institution as well as those assigned while abroad.**

Please mark the areas of the body picture below that reflect where you were injured and check the appropriate boxes to the left.

( ) Back
( ) Head
( ) Face
( ) Neck
( ) Shoulder
( ) Arm
( ) Wrist
( ) Hand
( ) Finger(s)
( ) Chest
( ) Abdomen
( ) Ribs
( ) Hips
( ) Buttocks
( ) Thigh
( ) Knee
( ) Leg
( ) Ankle
( ) Foot
( ) Other



Describe in detail the nature of your injury or endemic illness and how it happened (if more space needed, write on back of sheet)

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The above statement is true and accurate to the best of my knowledge. I confirm that the occurrence described above happened while I was performing my essential job duties that were assigned to me by The University of Texas System Institution and my employing department.

______________________________________ ____________________ __________

Injured Employee's Signature Date Extension

______________________________________ ____________________ __________

Supervisor's Signature Date Extension

Please email the <u>completed</u> First Report of Injury to UT System @ bholman@utsystem.edu.

Claims will be sent to Chubb @ ChubbClaimsFirstNotice@chubb.com

Note: Injured employees may be asked to provide Chubb with a passport or driver's license, proof of employment and related medical documentation/bills