STATE OFFICE of RISK MANAGEMENT

PRINT

EMPLOYEE'S REPORT OF INJURY

Dear Employee:

We have received a report that you were injured in the course of your employment. To process your claim efficiently, please fill in all lines completely and print legibly. **Attach additional sheets if necessary.**

Name: _____ (Last / First / MI / Maiden)

Address: _____

City: _____ State: Texas

Primary Phone Number: _____

Secondary Phone Number: _____

Email address: _____

Social Security: _____ Gender: M / F

Date of Injury: _____

Employer: Texas State University

Job Title: _____

Work Schedule: _____

1) What was the exact location of the accident (street address if possible):

2) What was happening at the time? (What was going on around you, what were you doing, what were other people doing)

3) Briefly describe what exactly caused the injury:

4) What areas of your body were injured?

5) When and to whom did you report your injury? Date _____ Time _____

Name: _____ Title _____ Phone Number: _____

6) List all known witnesses. (Continue on back if necessary) Name _____ Phone: _____

Name _____ Phone: _____ Name: _____ Phone: _____

7) Please identify your Primary Care Physician or family doctor: Name: _____ Phone: _____

8) Please list the names and phone numbers of all doctors or treatment providers you have seen for your injury:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

9) Has a doctor taken you off work? ☐ Yes ☐ No If so, when was the first day you missed work ? _____

10) If the doctor took you off work, have you returned to work? ☐ Yes ☐ No If not, when do you think you will return to work? _____

11) Date of Last Appointment: _____ 11) Date of Next Appointment: _____

12) Have you had previous workers compensation injuries? ☐ Yes ☐ No If Yes, please enter dates of injuries and the body parts injured.

By affixing my signature, I attest that all information on this form is accurate and true.

Signature: _____ Date: _____

Instructions
Employee's Report of Injury

Purpose of Form:

The injured employee completes this form to provide SORM with information pertaining to the circumstances surrounding the injury and what has happened since the date of injury. This will help to expedite benefits in a more timely manner.

Filing Deadline:

The form must be received by SORM not later than the 5th calendar day after the First Report of Injury or Illness (DWC-1S) is reported by the agency.

Completed by:

This form shall be completed by the injured employee with assistance from the Claims Coordinator, if needed.

Instructions:

1. The employee will address each of the questions completely and is to use additional pages if necessary. The adjuster needs a complete picture of the events surrounding the injury and how the injury occurred. Witnesses names and phone numbers, physicians/treatment providers names and phone numbers and work status is needed. The employee should enter any previous workers compensation claims and the body parts injured.

2. The injured employee will sign and date the form thereby attesting that all information on the form is true and complete.

Distribution

The Claims Coordinator shall retain the original for the agency file and fax or mail a copy to:

State Office *of* Risk Management
PO Box 13777
Austin, TX 78711
(512) 472-0228

Notice: With few exceptions, an individual is entitled, upon request, to be informed about the information a state governmental body collects about the individual. Under Sections 552.021 and 552.023 of the Government Code the individual is entitled to receive and review the information and under Section 559.004 of the Government Code the individual is entitled to have the state governmental body correct any information about the individual that is incorrect.