Employee Injury Report

This form is to be completed by the supervisor of the injured employee or a department representative. Print in ink all requested information. Return within 48 hours to UNTHSC Campus HR, 3500 Camp Bowie Blvd. Ste. 280, or email to Meagan.Voorhies@untsystem.edu. If you have questions, call (817) 735-2690.

Injured Employee Information

Name _____ Sex ☐ F ☐ M EMPL ID# _____

Address _____ Birthdate _____

City _____ State _____ ZIP _____ County _____

Home Phone _____ Work Phone _____

Marital Status ☐ Married ☐ Single Primary Language ☐ English ☐ Other _____

Department _____ DEPT ID# _____

Hire Date _____ Work Schedule _____ Hours per Week _____

Current Leave Balances Sick _____ Vacation _____ ☐ Non Benefits Eligible

Supervisor Name _____ Supervisor Phone _____

Injury Information

Date _____ Time _____ ☐ AM ☐ PM Employee Performing Regular Duties ☐ Yes ☐ No

Date Reported _____ Reported To _____

Site Where Injury Occurred _____

Body Part Injured (1) _____ ☐ Left ☐ Right / ☐ Upper ☐ Lower

Body Part Injured (2) _____ ☐ Left ☐ Right / ☐ Upper ☐ Lower

Type of Injury (cut, bruise, strain, etc.) _____

Detailed Description of How Injury Occurred _____

_____

_____

_____

Has Employee Been Off Work Due to Injury ☐ Yes ☐ No Beginning Date _____

Medical Treatment

Was Medical Treatment Required ☐ Yes ☐ No

Health Care Provider ☐ UNT Health Center ☐ ER ☐ Other _____

Completed By

Name _____ Phone _____

Signature _____ Date _____

UNT HEALTH SCIENCE CENTER

Employee Injury Investigation Report

This form is to be completed by the supervisor of the injured employee or a department representative. Print in ink all requested information. Return within 48 hours to UNTHSC Campus HR, 3500 Camp Bowie Blvd. Ste. 280, or email to Meagan.Voorhies@untsystem.edu. If you have questions, call (817) 735-2690.

Injured Employee Information

Name _____ Date of Injury _____

Department _____ DEPT ID# _____

Investigation

Activity at time of injury _____

Was the activity in the course and scope of employee's job duties? ☐ Yes ☐ No

If no, explain _____

_____

_____

Was the injury a result of a lack of training, poor physical layout, defective equipment, inadequate signage, or other physical hazards? ☐ Yes ☐ No

If yes, explain _____

_____

_____

Who was notified of the safety concern? _____

Was employee using personal protective equipment (PPE)? ☐ Yes ☐ No

Was PPE required for this activity? ☐ Yes ☐ No

Was PPE available to the employee? ☐ Yes ☐ No

Would PPE have prevented or lessened the severity of the injury? ☐ Yes ☐ No

Did the employee violate a safety rule, regulation or procedure? ☐ Yes ☐ No

If yes, explain _____

_____

_____

Was this violation discussed with the employee? ☐ Yes ☐ No

Did the injury result from the employee not being observant of workplace hazards, surroundings, signage, or safety training? ☐ Yes ☐ No

If yes, explain _____

_____

_____

Were there any witnesses? ☐ Yes ☐ No

If yes, was a Witness Statement (SORM-74) completed by each witness? ☐ Yes ☐ No

What other actions, events, or conditions directly contributed to the injury? _____

_____

_____

_____

What corrective actions have been taken to prevent a similar injury from occurring?_____

_____

_____

_____

What additional training, equipment, procedures, or other actions could prevent a similar injury from occurring? _____

_____

_____

Completed By

Name _____ Phone_____

Signature _____ Date _____

Safety Office Review

_____

_____

_____

_____

Reviewed By _____ Date _____

SORM
STATE OFFICE of RISK MANAGEMENT

WITNESS STATEMENT

MUST BE TYPED
OR PRINTED

Injured Employee _____
SORM Claim Number WC_____
Date of Injury _____
Statement Taken By _____

Witness Name:_____ Witness email address:_____
Residence Address:_____
Primary Telephone:_____ Secondary Telephone:_____
Witness Employer:_____

On this date, _____, at about _____ ☐ AM ☐ PM I was in or at (clearly state your own location) _____ when an accident involving the above employee is reported to have occurred.

Check only one box

☐ **I saw the incident.**
The accident occurred in the following manner: _____

Other pertinent information and source: _____

☐ **I did not see the incident.** Information given to me by (name of person) _____ indicates it occurred as follows: _____

Other pertinent information and source: _____

☐ I know nothing whatsoever about the occurrence.

_____ _____
Signature Date