☐ Report Only
☐ First Aid

☐ If Medical Treatment Required
Call Risk Management 972-882-7375 or 972-882-5561

RISK MANAGEMENT MUST PROVIDE AUTHORIZATION PRIOR TO MEDICAL TREATMENT

Employee Information

Employee ID # _____ Campus/Bldg Assigned _____

If injury did NOT occur at assigned campus/building, indicate site/address where injury occurred below

First Name _____ English Speaking? Circle one: YES NO

Last Name _____ If no, what language? _____

Home Address 1 _____ Birth Date MMDDYY _____

Home Address 2 _____ Gender _____

City / Zip _____ Marital Status _____

Phone _____ Job Title _____

Work Phone _____ # of Dependents _____

Employee Email _____

Occurrence Information

Date of Injury/Illness MMDDYY _____

Time EE Began Work _____ AM / PM

Time of Injury or Illness _____ AM / PM

Date Supervisor Notified _____

Supervisor Name _____

Supervisor Phone # _____

Body Part(s): Include Left/Right, Upper/Lower

Cause of Injury (trip/fall, tool, machinery, bite, etc)

Worksite Location of Injury (classroom, hallway, kitchen)

Was Employee Doing their Regular Job? ☐

Treatmant Information

Workers' Comp Alliance Medical Provider _____

Provider Address _____

Provder Phone _____ Fax _____

Witness Name _____ Witness Phone _____

Employee Signature _____ Date _____

Admin. Signature _____ Date _____

RISK MANAGEMENT OFFICE USE ONLY - DO NOT WRITE BELOW

SSN		Hire Date		Hourly	$	Daily	$
Weekly	$	Weekly Hours		Campus #		Job Code	
Date Last Check		Amt. Last Check	$	Annual Pay	$		
Days Worked Yearly		Stipends					
Type of Injury							

ATTACH Detailed Written Statement: How Injury Occurred (Sequence of Events)