Workers' Compensation

Supervisor

Forms

UNT's Risk Management office will file and coordinate claim documentation for your work-related injury. Benefit eligibility is determined by law and evaluated by the State Office of Risk Management (SORM). Once a claim has been filed, the SORM adjuster is the primary point of contact; however, RMS is also available to answer questions.
You may visit https://www.sorm.state.tx.us/claims-operations/the-texas-state-employees-workers-compensation-system for more details.

RISK MANAGEMENT SERVICES
UNIVERSITY OF NORTH TEXAS™

Employee Injury Investigation Report

This form is to be completed by the supervisor of the injured employee or a department representative. Return within 48 hours to Risk Management Services, Insurance & Claims at RMS@unt.edu. If you have questions, call (940) 565-2109.

Injured Employee Information

Name ______________________________ Date of Injury ______________________

Department ______________________________ DEPT ID# ______________________

Employee 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 ______________________________

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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 ______________________________

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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 ______________________________

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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 ____

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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? ______________________________

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

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

____

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Completed By

Name ______________________________ Phone ______________________________

Signature ______________________________ Date ______________________________

Risk Management Review

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Reviewed By ______________________________ Date ______________________________

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

SORM-74 Rev 07/09