RISK MANAGEMENT SERVICES

UNIVERSITY OF NORTH TEXAS™

Employee Injury Report

This form is to be completed by the **supervisor** of the injured employee or a department representative. Email the form within 48 hours of an incident to Risk Management Services, Insurance & Claims. Email the completed report to rms@unt.edu using '#secure' in the subject line to securely send the email. If you have questions, call (940) 565-2109.

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 _____