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 your claim has been filed, your insurance adjuster will be your 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 Report

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 _____ Sex ☐ F ☐ M EMPL ID# _____

Home Phone _____ Work Phone _____ Email _____

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

Department _____ Job Title _____

Dept ID _____ Work Schedule _____ Hours per Week _____

Current Leave Balances Sick _____ Vacation _____ ☐ No Benefits Hire Date _____

Supervisor Name _____ Supervisor Phone _____

Supervisor Email _____

Injury Information

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

Date Reported _____ Reported To _____

Site Where Injury Occurred _____

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

If so, when have they returned to work (if applicable)?

Medical Treatment Information

Was Medical Treatment Required? ☐ Yes ☐ No

If so, was the employee hospitalized overnight? ☐ Yes ☐ No

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

Completed By

Name _____ Phone _____

Signature _____ Date _____

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. Print in ink all requested information. Return within 48 hours to Risk Management Services, Insurance & Claims, 700 North Texas Boulevard, or fax to (940) 369-7611. If you have questions, call (940) 565-2109.

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 _____

Risk Management 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