UNIVERSITY OF TEXAS ARLINGTON

Environmental Health and Safety

Form CO-EHS-F402
11/2023

Supervisor's Report of Employee Work-Related Injury or Occupational Disease

Personal Information:

Name of Injured Employee: _____ Employee Extension: _____ Does not have personal extension □

What is the best number to contact employee? _____

Does your injured employee speak English? Yes □ No □ If no, what language? _____

Job Information:

Employee's Position/Title: _____ Dept. Where Employed: _____

Length of service in current position:_____ Employee's normal work week (Ex.: Mon-Fri, 7am - 4pm, no lunch) _____

Please provide the current leave balances as of the date of injury. Sick: _____ *Vacation:* _____ *Compensatory:*_____

Incident Information:

Date of Injury: _____ Time of Injury: _____ a.m. □ p.m. □

When were you notified about this injury? Date: _____ Time: _____ a.m. □ p.m. □

Are you the employee's direct supervisor? Yes □ No □ If no, who is the direct supervisor? _____

Has your employee missed a full workday(s) because of this injury (excluding the day of injury)? Yes □ No □

Excluding the day of injury, what was the first scheduled workday missed? _____ N/A □

Return to work date (if known):_____

Worksite where injury happened (Ex: Administrative Bldg., Sidewalk, 2nd floor elevators, Lab):

Building/Room # _____

Description of Area _____

Based on your inquiry, what was your employee doing at the time of the injury. *(Ex.: "The employee stated he was walking into the building, slipped on the wet tile and fell to his knees causing a bruise to his left knee")*.

When the injury happened, was your employee performing their regular duties or a specific task assigned to them? Yes □ No □

If no, please describe what they were doing at the time of the reported injury.

Was there physical evidence of injury to the claimed body parts? Yes □ No □ N/A □

If yes, please describe (Ex.: scratch on upper left arm, cut to top of head/scalp, bruised right knee)

Were there any witnesses to this injury? Yes □ No□ If yes, list name(s) and phone number(s). Attach an additional sheet, if necessary.

1. _____ Contact # or email _____

What do you think may prevent this type of accident from happening in the future?

Medical Information:

Did you provide the employee the required WC Network Acknowledgement form & Notice of Network Requirements packet on how to get healthcare under workers' compensation insurance? Yes □ No □

Initial Medical Treatment: Yes □ No □ First Aid Only Yes □ No □ Physician/Treatment Facility Yes □ No □ ER Visit Yes □ No □

Supervisor's Signature: (**Required):** _____Date: _____

Print Supervisor's Name: _____Ext._____Supervisor's Email Address: _____

This form was completed by ***(if other than the supervisor)***:

Print Name _____ Ext: _____Email Address: _____

Scan completed forms and email to workerscompensation@uta.edu

Please be aware that signing this report is not an admission by or evidence against UT Arlington. The information contained in this report only documents the supervisor's knowledge or version of how this incident occurred.

(You may be entitled to know what information The University of Texas at Arlington (UT Arlington) collects concerning you. You may review and have UT Arlington correct the information according to procedures set forth in UTS 139. The law is found in sections 552.021, 552.023 and 559.004 of the Texas Government Code.)

Revised: 11/23