



Human Resources Department

301 University Blvd., Rt. 0985
Galveston, TX 77555-0985
Tel. 409-797-8150 □ Fax 409-747-0860

Instructions for Worker's Compensation Incidents

A report must be filed with Texas Mutual Insurance Company under UTMB HealthCare Systems' Worker's Compensation Insurance Plan for each illness, injury, or incident involving an employee while on the job. All of the attached forms must be completed and forwarded to UTMB HealthCare Systems' Human Resources Department at 301 University Blvd., Rt. 0985, Galveston, TX 77555-0985.

<i>Forms</i>	<i>To be completed by</i>
Illness/Injury/Incident Report	Staffing Coordinator on duty at time of incident
Employee Medical Evaluation	Physician and Employee
Return to Work Certification	Physician

Please provide the following information to the physician's office:

Worker's Comp Carrier	Texas Mutual Insurance Fund	Policy #0001093707 Telephone - (800) 859-5995
Claims	Reporting and information	Telephone (800) 892-5246 Fax (877) 404-7999
	Mailing Address	Benefit Services Division (Claims) P. O. Box 12029 Austin TX 78711-2029

For questions, please contact UTMB HealthCare Systems' Human Resources Department at 409-797-8150. May 22, 1996



Illness/Injury/Incident Report

Confidential

Today's Date _____

Please print or type in black ink. This report must be completed within 24 hours of the illness, injury, or incident and forwarded to Human Resources, 301 University Blvd., Route 0985, Galveston, TX 77555-0985.

Section 1. To be completed by Employee.

Name of Injured		Sex	Social Security Number	DOB
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Spouse's Name (if applicable)		# of Dependent Children
Home Address			City	State
County of Residence	Phone ()	E-mail address		
Date of Hire	Employee's Occupation	Length of Service ____ Years ____ Months	Department and Extension #	
Date of Incident	Time of Incident <input type="checkbox"/> AM <input type="checkbox"/> PM	Date Reported	Job Task at Time of Incident	
Employee was Working <input type="checkbox"/> Alone <input type="checkbox"/> With fellow workers <input type="checkbox"/> Other _____		Employment Category <input type="checkbox"/> Regular full-time <input type="checkbox"/> Contract <input type="checkbox"/> Regular part-time <input type="checkbox"/> Temporary <input type="checkbox"/> Per diem <input type="checkbox"/> Non-employee		Experience in Occupation at Time of Incident <input type="checkbox"/> Less than 1 month <input type="checkbox"/> 1 to 5 months <input type="checkbox"/> 6 months to 1 year <input type="checkbox"/> 1 to less than 5 yrs. <input type="checkbox"/> 5 or more years
Phase of Employee's Workday at Time of Injury <input type="checkbox"/> During break period <input type="checkbox"/> During meal period <input type="checkbox"/> Entering or leaving building <input type="checkbox"/> Working overtime <input type="checkbox"/> Performing work duties <input type="checkbox"/> Other _____		Specific Location of Incident <input type="checkbox"/> Office <input type="checkbox"/> Stairs <input type="checkbox"/> Photocopy room <input type="checkbox"/> Restroom <input type="checkbox"/> Elevator <input type="checkbox"/> Break room <input type="checkbox"/> Home visit <input type="checkbox"/> Lobby <input type="checkbox"/> Office grounds <input type="checkbox"/> Parking area <input type="checkbox"/> Vehicle <input type="checkbox"/> Meeting room <input type="checkbox"/> Hallway <input type="checkbox"/> Sidewalk <input type="checkbox"/> Other _____		Witness(es) 1. Name _____ Phone# _____ 2. Name _____ Phone# _____
Employee's Description of Incident (If additional space is needed, attach separate sheet of paper.) Please print. <hr/> <hr/> <hr/> <hr/> 				
Employee's Signature _____			Date _____	

Section 2. To be completed by Supervisor.

Incident occurred on employer's premises? <input type="checkbox"/> Yes <input type="checkbox"/> No Employee sent to <input type="checkbox"/> Hospital <input type="checkbox"/> Doctor	Severity <input type="checkbox"/> No apparent injury <input type="checkbox"/> Medical treatment <input type="checkbox"/> First Aid <input type="checkbox"/> Fatality <input type="checkbox"/> Lost work days <input type="checkbox"/> Other _____
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Supervisor's Description of Incident <hr/> <hr/> <hr/>		
Supervisor's Signature _____		Date _____
Witnessed Incident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name and Address of Treating Physician _____ _____ Phone _____	Name and Address of Hospital _____ _____ Phone # _____	Disposition <input type="checkbox"/> Days away from work # _____ <input type="checkbox"/> Restricted work days # _____ <input type="checkbox"/> Date returned to work ____/____/____

What condition of tools, equipment, or work area contributed to incident?	
<input type="checkbox"/> Not applicable	
<input type="checkbox"/> Hazardous placement	<input type="checkbox"/> Inadequate guards/barriers
<input type="checkbox"/> Floors/Work space	<input type="checkbox"/> Defective tools/equip/vehicle
<input type="checkbox"/> Inadequate ventilation	<input type="checkbox"/> Equipment/workstation design
<input type="checkbox"/> Illumination	<input type="checkbox"/> Inadequate/improper PPE
<input type="checkbox"/> Equipment failure	<input type="checkbox"/> Close clearance/congestion
<input type="checkbox"/> Inadequate housekeeping	<input type="checkbox"/> Inadequate warning system

What caused or influenced substandard conditions?	
<input type="checkbox"/> Not applicable	
<input type="checkbox"/> Abuse or misuse	<input type="checkbox"/> Inadequate purchasing
<input type="checkbox"/> Inadequate maintenance	<input type="checkbox"/> Improper work surfaces
<input type="checkbox"/> Lack of knowledge/training	<input type="checkbox"/> Inadequate guards/barriers
<input type="checkbox"/> Inadequate supervision	<input type="checkbox"/> Defective tools/equip/vehicle
<input type="checkbox"/> Inadequate tools/equip/mat.	<input type="checkbox"/> Illumination
<input type="checkbox"/> Improper motivation	<input type="checkbox"/> Inadequate/improper PPE

What action or inaction contributed to the incident?	
<input type="checkbox"/> Not applicable	
<input type="checkbox"/> Failure to make secure	<input type="checkbox"/> Under influence drugs/alcohol
<input type="checkbox"/> Used equipment improperly	<input type="checkbox"/> Operating procedure deviation
<input type="checkbox"/> Improper loading	<input type="checkbox"/> Servicing/operating equipment
<input type="checkbox"/> Improper technique	<input type="checkbox"/> Running/rushing/acting in haste
<input type="checkbox"/> Failure to warn/signal	<input type="checkbox"/> Used wrong tool/equipment
<input type="checkbox"/> Used defective equipment	<input type="checkbox"/> Inadequate/improper PPE use
<input type="checkbox"/> Improper lifting	<input type="checkbox"/> Operating at improper speed
<input type="checkbox"/> Unauthorized actions	<input type="checkbox"/> Nullified safety/control devices
<input type="checkbox"/> Improper position	<input type="checkbox"/> None
<input type="checkbox"/> Horseplay/distractive action	<input type="checkbox"/> Other _____

Preventive measures recommended	
<input type="checkbox"/> Not applicable	
<input type="checkbox"/> Improve enforcement	<input type="checkbox"/> Complete task analysis
<input type="checkbox"/> Repair/replace equipment	<input type="checkbox"/> Use other materials/supplies
<input type="checkbox"/> Identify/improve PPE	<input type="checkbox"/> Install/revise guards/devices
<input type="checkbox"/> Improve design/construction	<input type="checkbox"/> Reassign job of employee
<input type="checkbox"/> Improve illumination	<input type="checkbox"/> Mandatory pre-job instructions
<input type="checkbox"/> Re-instruction of employee	<input type="checkbox"/> Improve/change work method
<input type="checkbox"/> Rotation of employee	<input type="checkbox"/> Task analysis/procedure revision
<input type="checkbox"/> Improve ventilation	<input type="checkbox"/> Improve storage/arrangement
<input type="checkbox"/> Corrective counseling	<input type="checkbox"/> Improve clean-up procedures
<input type="checkbox"/> Eliminate congestion	<input type="checkbox"/> Other _____

Probability of recurrence
<input type="checkbox"/> Frequent <input type="checkbox"/> Occasional <input type="checkbox"/> Rare

Loss severity potential
<input type="checkbox"/> Major <input type="checkbox"/> Serious <input type="checkbox"/> Minor

Specific corrective actions or preventive measures taken			
Corrective Action Taken	Person Responsible	Target Date	Date Completed
Supervisor's Signature	Date	HR Representative Signature	Date

EMPLOYEE MEDICAL EVALUATION

Section 1. To be completed by Employee.

Name of Injured	SSN	Today's Date
Home Address	City	State/Zip

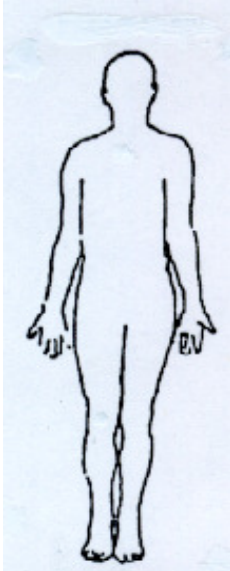

Section 2. To be completed by Physician.

Physician notified? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ Time _____ By whom? _____
Did Employee see a Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If 'Yes,' time seen _____
Physician's Name _____
Physician's Mailing Address _____

LOCATION OF INJURY ON BODY

TYPE OF INJURY

TYPE OF INCIDENT

<input type="checkbox"/> Left Side <input type="checkbox"/> Right Side <input type="checkbox"/> Front <input type="checkbox"/> Back <input type="checkbox"/> Head <input type="checkbox"/> Face <input type="checkbox"/> Neck <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Finger(s) <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Ribs <input type="checkbox"/> Hips <input type="checkbox"/> Buttocks <input type="checkbox"/> Thigh <input type="checkbox"/> Knee <input type="checkbox"/> Leg <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Other: _____	<p>FRONT VIEW</p> <p>R L L R</p> <div style="display: flex; justify-content: space-around;">   </div>	<input type="checkbox"/> Abrasion <input type="checkbox"/> Allergic Reaction <input type="checkbox"/> Anoxia <input type="checkbox"/> Asphyxia <input type="checkbox"/> Burn <input type="checkbox"/> Concussion <input type="checkbox"/> Contagious Disease <input type="checkbox"/> Contusion <input type="checkbox"/> Dislocation <input type="checkbox"/> Fracture <input type="checkbox"/> Heat/Cold Stress <input type="checkbox"/> Infection <input type="checkbox"/> Injection Site Injury <input type="checkbox"/> Internal Injury <input type="checkbox"/> Irritation <input type="checkbox"/> Laceration <input type="checkbox"/> Puncture <input type="checkbox"/> Sprain <input type="checkbox"/> Strain <input type="checkbox"/> Sharps Exposure <input type="checkbox"/> Mucosal Splash <input type="checkbox"/> No Apparent Injury <input type="checkbox"/> Other: _____	<input type="checkbox"/> Struck by <input type="checkbox"/> Struck against <input type="checkbox"/> Caught in <input type="checkbox"/> Caught On <input type="checkbox"/> Caught Between <input type="checkbox"/> Fall <input type="checkbox"/> Slip <input type="checkbox"/> Ingestion <input type="checkbox"/> Inhalation <input type="checkbox"/> Loss/Theft <input type="checkbox"/> Damage of Property <input type="checkbox"/> Lifting/Moving <input type="checkbox"/> Policy/Procedure Break <input type="checkbox"/> Failure to Follow Orders <input type="checkbox"/> Automobile <input type="checkbox"/> Shock <input type="checkbox"/> Bite <input type="checkbox"/> Other: _____
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Physician Signature _____ Date _____

Telephone _____ Fax _____ SS# or E.I.N. # _____