



The University of Texas at El Paso Supervisor's Incident and Injury Report

INSTRUCTIONS FOR COMPLETING THIS FORM: This form is to be completed by the reporting department supervisor or administrator within 24 hours of the incident first being reported. The form may be filled in on your computer or printed out and completed manually. Please make sure to print legibly, fill in all of the information or indicate "Not Applicable."

Section 1. Injured Faculty, Staff, Student Information	
1a. Name: Street/PO Box Address: City, State, Zip: Home/Cell Tel. No.:	UTEP 600# Date of Birth: Sex: <input type="checkbox"/> Male Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Female <input type="checkbox"/> Divorced <input type="checkbox"/> Separated
1c. Employment Status: <input type="checkbox"/> Faculty <input type="checkbox"/> Staff <input type="checkbox"/> Student Worker <input type="checkbox"/> Student	1d. Does this person speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No If NO, please specify language:
1e. Name of Reporting Department:	1f. If Faculty/Staff, or Student Worker: Hire Date (Mo/Yr):

Section 2. Injury/Incident Details																																																													
2a. Date Injury or Incident Occurred: Specific Time That Injury Occurred: AM <input type="checkbox"/> PM <input type="checkbox"/>	2b. Date Injury or Incident Reported: Time Injury or Incident Reported: AM <input type="checkbox"/> PM <input type="checkbox"/>																																																												
2c. Injury/Incident Type: <input type="checkbox"/> Abrasion <input type="checkbox"/> Bite (Animal, Insect) <input type="checkbox"/> Burn <input type="checkbox"/> Chemical Spill <input type="checkbox"/> Contusion <input type="checkbox"/> Exposure <input type="checkbox"/> Fall, Slip, Trip <input type="checkbox"/> Sprain/Strain <input type="checkbox"/> Needle Stick <input type="checkbox"/> Vehicular Accident/Incident <input type="checkbox"/> Other, please describe:	2d. Injured Body Part (s): <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 60%;"></th> <th style="width: 10%;"></th> <th style="width: 10%; text-align: center;">Right</th> <th style="width: 10%; text-align: center;">Left</th> </tr> </thead> <tbody> <tr><td><input type="checkbox"/> Head</td><td><input type="checkbox"/> Eye</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Face</td><td><input type="checkbox"/> Lower Arm</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Neck (soft tissue)</td><td><input type="checkbox"/> Upper Arm</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Neck (spinal)</td><td><input type="checkbox"/> Shoulder</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Chest</td><td><input type="checkbox"/> Hand</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Lower Back</td><td><input type="checkbox"/> Wrist</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Upper Back</td><td><input type="checkbox"/> Finger</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td><input type="checkbox"/> Coccyx (tailbone)</td><td><input type="checkbox"/> Upper Leg</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td></td><td><input type="checkbox"/> Lower Leg</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td></td><td><input type="checkbox"/> Knee</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td></td><td><input type="checkbox"/> Ankle</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td></td><td><input type="checkbox"/> Foot</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td></td><td><input type="checkbox"/> Toe</td><td style="text-align: center;"><input type="checkbox"/></td><td style="text-align: center;"><input type="checkbox"/></td></tr> <tr><td colspan="2"><input type="checkbox"/> None, Incident Only</td><td></td><td></td></tr> </tbody> </table>			Right	Left	<input type="checkbox"/> Head	<input type="checkbox"/> Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Face	<input type="checkbox"/> Lower Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck (soft tissue)	<input type="checkbox"/> Upper Arm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Neck (spinal)	<input type="checkbox"/> Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lower Back	<input type="checkbox"/> Wrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Upper Back	<input type="checkbox"/> Finger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Coccyx (tailbone)	<input type="checkbox"/> Upper Leg	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Lower Leg	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Knee	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Ankle	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Foot	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> Toe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> None, Incident Only			
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2e. Severity of Injury: <input type="checkbox"/> Injured Person Received Medical Care <input type="checkbox"/> Injured Person Refused Medical Care	2f. Cause of Injury/Incident: <input type="checkbox"/> Walking Surface <input type="checkbox"/> Ladder <input type="checkbox"/> Material Handling <input type="checkbox"/> Stairs, Steps <input type="checkbox"/> Machine/Tool <input type="checkbox"/> Person <input type="checkbox"/> Vehicle <input type="checkbox"/> Needle												
2g. Describe how the injury or incident occurred:													
2h. Location where the incident or accident occurred: Building: Floor: Room #: Description of area: <input type="checkbox"/> Office <input type="checkbox"/> Lab <input type="checkbox"/> Hallway <input type="checkbox"/> Stairwell <input type="checkbox"/> Parking Lot <input type="checkbox"/> Grounds <input type="checkbox"/> Off Campus Location	2i. Was this person performing his/her regular duties? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain:												
2j. Was the injured person wearing personal protective equipment (PPE)? <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify PPE Used: <input type="checkbox"/> Safety Glasses <input type="checkbox"/> Face Shield <input type="checkbox"/> Gloves <input type="checkbox"/> Hard/Bump Hat <input type="checkbox"/> Respiratory Protection <input type="checkbox"/> Fall Protection <input type="checkbox"/> Hearing Protection	2k. Was training provided to this person to perform this task or operate this equipment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable Date Training Provided:												
2l. Who witnessed this injury or incident? <table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">Name</td> <td style="width: 33%;">Campus Extension</td> <td style="width: 33%;">Campus Email</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td>Name</td> <td>Campus Extension</td> <td>Campus Email</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table> NO ONE: <input type="checkbox"/>		Name	Campus Extension	Campus Email				Name	Campus Extension	Campus Email			
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3. Injured Person Printed Name and Signature (Not required, but requested for the purpose of documenting report accuracy.) <table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">Printed Name</td> <td style="width: 33%;">Title</td> <td style="width: 33%;">Campus Ext. and/or Cell Phone #</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Signature</td> <td>Date</td> <td>UTEP Email Address</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>		Printed Name	Title	Campus Ext. and/or Cell Phone #	_____	_____	_____	Signature	Date	UTEP Email Address	_____	_____	_____
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4. Name and signature of Department Head or Supervisor (Required) <table border="0" style="width: 100%;"> <tr> <td style="width: 33%;">Printed Name</td> <td style="width: 33%;">Title</td> <td style="width: 33%;">Campus Ext. and/or Cell Phone #</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>Signature</td> <td>Date</td> <td>UTEP Email Address</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>		Printed Name	Title	Campus Ext. and/or Cell Phone #	_____	_____	_____	Signature	Date	UTEP Email Address	_____	_____	_____
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When completed and signed please forward original form to the Environmental Health & Safety Office (EH&S). A copy may be faxed to EH&S at 747-8126. The form should be received at EH&S within 24 hours of the incident. To notify EH&S via phone, please call 747-7124 or 747-7197; or, email notification to tgquiroz@utep.edu or rlozano4@utep.edu. Questions regarding Workers' Compensation or this form may be directed to 747-7124 or 747-7197.

The University of Texas at El Paso



Workers' Compensation Network Acknowledgement Form

I have received information (Employee Welcome Letter, Notice of Network Requirements and Employee Handbook Material) which informs me how to get health care under workers' compensation insurance.

If I am hurt on the job and live in the service area described in this information, I understand that:

1. I must choose a treating doctor from the list of physicians in the **IMO Med-Select Network**[®]. Or, I may ask my HMO primary care physician to agree to serve as my treating doctor by completing the Selection of HMO Primary Care Physician as Workers' Compensation Treating Doctor Form # IMO MSN-5.
2. I must go to my network treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
3. The insurance carrier will pay the treating doctor and other network providers.
4. I *may have to pay* the bill if I get health care from someone other than a network doctor without Network approval.
5. If I receive the Notice of Network Requirements and refuse to sign the Acknowledgement form, *I am still required to use the network.*

Please fill out the following information before signing and submitting this completed acknowledgement form:

Name of Carrier: The University of Texas System

Employee ID #: _____ **Name of Network:** IMO Med-Select Network[®]

Hire Date: _____ **Department:** _____

Injury Date: _____

Home Address:
Street Address – No P.O. Box or Work Address

City State Zip Code County

Employee Signature

Date

Printed Name

Contact Information
Tania G. Quiroz, WC Advisor
915-747-7197/740-1119
wci@utep.edu