EH&S
ENVIRONMENTAL HEALTH & SAFETY

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: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated
1c. Employment Status: ☐ Faculty ☐ Staff ☐ Student Worker ☐ Student	1d. Does this person speak English? ☐ Yes ☐ 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 ☐ PM ☐	2b. Date Injury or Incident Reported: Time Injury or Incident Reported: AM ☐ PM ☐

2c. Injury/Incident Type:

- ☐ Abrasion
- ☐ Bite (Animal, Insect)
- ☐ Burn
- ☐ Chemical Spill
- ☐ Contusion
- ☐ Exposure
- ☐ Fall, Slip, Trip
- ☐ Sprain/Strain
- ☐ Needle Stick
- ☐ Vehicular Accident/Incident
- ☐ Other, please describe:

2d. Injured Body Part (s):

		Right	Left
☐ Head	☐ Eye	☐	☐
☐ Face	☐ Lower Arm	☐	☐
☐ Neck (soft tissue)	☐ Upper Arm	☐	☐
☐ Neck (spinal)	☐ Shoulder	☐	☐
☐ Chest	☐ Hand	☐	☐
☐ Lower Back	☐ Wrist	☐	☐
☐ Upper Back	☐ Finger	☐	☐
☐ Coccyx (tailbone)	☐ Upper Leg	☐	☐
	☐ Lower Leg	☐	☐
	☐ Knee	☐	☐
	☐ Ankle	☐	☐
	☐ Foot	☐	☐
	☐ Toe	☐	☐

☐ None, Incident Only

2e. Severity of Injury:

☐ Injured Person Received Medical Care

☐ Injured Person Refused Medical Care

2f. Cause of Injury/Incident: ☐ Walking Surface ☐ Ladder ☐ Material Handling ☐ Stairs, Steps ☐ Machine/Tool ☐ Person ☐ Vehicle ☐ Needle

2g. Describe how the injury or incident occurred:

2h. Location where the incident or accident occurred:

Building: **Floor:** **Room #:**

Description of area: ☐ Office ☐ Lab ☐ Hallway ☐ Stairwell ☐ Parking Lot ☐ Grounds ☐ Off Campus Location

2i. Was this person performing his/her regular duties?

☐ Yes ☐ No

If no, please explain:

2j. Was the injured person wearing personal protective equipment (PPE)?

☐ Yes ☐ No

Please specify PPE Used:

☐ Safety Glasses ☐ Face Shield ☐ Gloves
☐ Hard/Bump Hat ☐ Respiratory Protection
☐ Fall Protection ☐ Hearing Protection

2k. Was training provided to this person to perform this task or operate this equipment? ☐ Yes ☐ No ☐ Not Applicable

Date Training Provided:

2l. Who witnessed this injury or incident?

Name **Campus Extension** **Campus Email**

Name **Campus Extension** **Campus Email**

NO ONE: ☐

3. Injured Person Printed Name and Signature (Not required, but requested for the purpose of documenting report accuracy.)

Printed Name **Title** **Campus Ext. and/or Cell Phone #**

_____ _____ _____

Signature **Date** **UTEP Email Address**

4. Name and signature of Department Head or Supervisor (Required)

Printed Name **Title** **Campus Ext. and/or Cell Phone #**

_____ _____ _____

Signature **Date** **UTEP Email Address**

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
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