EMPLOYEE'S REPORT OF INJURY OR ILLNESS

(Continue On Reverse If Additional Space Is Necessary)

Information required by Texas Administrative Code, Title 28, Part 2, §120.1 and Texas Labor Code §402.082	
Name of Injured Employee (Payroll Name):	Today's Date:
SSN:	
Mailing address:	Home Phone: ( )
Do you speak English? ☐ Yes ☐ No ☐ Other language (Specify)	Race: ☐ White ☐ Black ☐ Asian
Ethnicity: ☐ Hispanic ☐ Native American ☐ Other	Marital Status: ☐ Married ☐ Widowed ☐ Separated ☐ Single ☐ Divorced
Spouse's Name:	# of Dependent Children: / Campus/Dept:
Your supervisor's name and telephone:	
Date of Injury:	**Time** of Injury:
Where were you located when you were injured?	
Nature of injury: (Strain, Sprain, Bruise, etc)	Body part(s) injured (Where? Left or right? Upper or lower?):
Have you lost any time from work? ☐ Yes ☐ No (***After*** the date of injury) Did you lose consciousness? ☐ Yes ☐ No	Specify Lost Dates/Hours: (***AFTER*** the date of injury)
What happened?	
List any ***ADULT*** witnesses:	
Have you seen (or will you see) a medical provider outside HCISD? ☐ Yes ☐ No ☐ Not Now - Maybe Later	
If yes, medical provider's name and contact information:	Did a medical provider give you a written prescription or a prescription medicine? ☐ Yes ☐ No
Printed name:	Signature:
Supv Printed Name:	Signature: