Texas Tech University System
First Report of Injury/Illness/Accident

Print Form

This form must be completed and signed by the Administrator/ Supervisor, not the employee

Submit completed form to: Texas Tech University System, Risk Management Department, MS2003, Lubbock, Texas. (FAX: 806-742-3018).

Please print or type.

1. Name (Last, First, MI)	2. Sex: ☐ Female ☐ Male
3. SSN / 4. Home Phone / 5. Date of Birth	
6. Mailing Address (Home) City_____State_____ Zip Code_____	
7. Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced	8. Number of Dependent Children
9. Spouse's Name	10. Does the employee speak English? If no, specify language. ☐Yes ☐No
11. Department	
12. Office Phone	
13. Supervisor's Name	

14. Date of Accident	15. Time of Accident ☐ AM ☐ PM
16. Was employee doing his/her regular job? ☐ Yes ☐ No	
17. Address where accident or exposure occurred. Name of business if accident occurred in a business site. City_____State_____ Code_____	
18. Cause of accident (struck, fall, strain, etc.)	
19. How and why Accident/Exposure occurred	
20. Part of body injured or exposed	
21. List Witnesses	
22. Date Reported to Supervisor	

23. Print Name (Must be Administrator/Supervisor)	Date
24. Signature (Must be Administrator/Supervisor)	Date

Complete the following sections ONLY IF medical treatment or lost time from work is involved.

25. Treating Doctor Name _____ Address_____ City _____ State _____ Zip Code_____ Phone Number _____	26. Date Lost Time Began 27. Return to work date or expected date

NOTE: With few exceptions, you are entitled by law to know, review, and correct information that we collect about you. For more information, please refer to OP 01.04.

ATTACHMENT A
OP 70.13
6/25/10