DEPARTMENT OF HUMAN RESOURCES

505 South McColl Road, Ste. A• Edinburg, Texas 78539 • (956) 318-2660

RECORD ONLY

MEDICAL

LOSS TIME

EMPLOYEE INCIDENT/INJURY REPORT

Employee's Name:	Incident Date:
Department Name:	Incident Time:
Social Security No.:	Work Schedule:
Job Title:	Days Off:
Home Address:	
City:	Supervisor's Name:
State:	Supervisor's Phone No.:
Zip Code:	
Mailing Address:	Date Supervisor Notified of Incident:
Telephone No:	Time Supervisor Notified of Incident:
Date of Birth:	Report Prepared By:

1) Explain in detail how incident occurred: (If additional space is required, continue on back or attach another page to this form)

2) List witnesses present at time of incident

3) Address and location of where incident occurred?

3a) Describe cause of injury:

4) Cause of incident/accident:
- Fleet accident
- Equipment
- Other/Identify ____________

4a) List all body part(s) affected:

4b) Name, address & phone no. of third party if applicable:

5) If medical claim, list physician/hospital; address & phone no.:

6) The following is for statistical purposes only and required by the Texas Department of Insurance/Div. of Workers' Comp. Commission:

Marital Status: Married Widowed Single Divorced Common Law

Spouses Name: ____________ **No. of Dependents:** ____________

Ethnicity: Hispanic Asian Black White Native American Other

Section 415.008 Texas Workers Compensation Act - Fraud occurs when a person knowingly or intentionally conceals, misrepresents or makes a false statement to obtain workers' compensation benefits or insurance coverage or otherwise profit from deceit. Any person who knowingly or intentionally engages in or conspires to commit one of the enumerate fraudulent acts for the purpose of obtaining workers' compensation benefits is subject to administrative penalty.

I certify that the above statements are true. I understand that by obtaining workers' compensation benefits to which I am not legally entitled to will lead to potential filing of criminal charges. I understand that failing to fill this form in its entirety will potentially slow the processing of my claim.

Print Name ____________ Signature ____________ Date ____________