

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



**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: <input type="checkbox"/> Female <input type="checkbox"/> Male		14. Date of Accident	15. Time of Accident <input type="checkbox"/> AM <input type="checkbox"/> PM
3. SSN	4. Home Phone	5. Date of Birth		16. Was employee doing his/her regular job? <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Mailing Address (Home)  City _____ State _____ Zip Code _____				17. Address where accident or exposure occurred. Name of business if accident occurred in a business site.  City _____ State _____ Code _____	
7. Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		8. Number of Dependent Children		18. Cause of accident (struck, fall, strain, etc.)	
9. Spouse's Name		10. Does the employee speak English? If no, specify language. <input type="checkbox"/> Yes <input type="checkbox"/> No		19. How and why Accident/Exposure occurred	
11. Department				20. Part of body injured or exposed	
12. Office Phone				21. List Witnesses	
13. Supervisor's Name				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  <hr/> 27. Return to work date or expected date
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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.