Personnel Injury Report

TEXAS CHRISTIAN UNIVERSITY

Return form to:

Risk Management Offices
Attn: Hao Brown
Box 297110, Secrest-Wible Bdlg. Rm 115
817-257-7778

DEPARTMENT INFORMATION (To be completed by supervisor)

Department: Supervisor: Ext:

EMPLOYEE INFORMATION

Name: Job title:

Address: Home phone:

City: Zip code: Date of Birth: TCU ID Number:

Did the employee miss work: Has the employee returned to work: Date/time of return:

Full/Part time employee: Was this his/her regular position: Normal shift time:

ACCIDENT INFORMATION

Date of accident: Time of accident: , Date of report:

Date injury was reported: To whom was it reported:

Describe the accident:

Location of the accident:

Describe the injury:

MEDICAL INFORMATION

Did not want treatment (✓): Taken to Hospital/clinic (✓):

Driven to doctor by friend/other individual (✓): Transported by ambulance (✓):

Treating physician: Name of hospital/clinic:

WITNESS INFORMATION

Name/Address: Daytime phone:

Name/Address: Daytime phone:

FOLLOW-UP INFORMATION

What actions have been taken to prevent a re-occurrence of this incident:

Texas Workers' Compensation law requires the investigation of each on-the-job accident, injury or illness. Representatives of the TCU risk management offices may contact you, witnesses to the incident, or the injured employee as part of this investigation.

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