



Risk Management

Instructions:

- 1. Supervisor / Principal must call Risk Management at 351-5200 immediately after an accident has been reported.
2. Supervisor / Principal must submit this Accident Report to the Risk management Department within 24 hours after an accident has been reported.
3. Supervisor / Principal must complete Page 1 (General Information) and Page 2 (Supervisor / Principal Accident Investigation and Corrective Action).
4. Failure to complete this report is a Class D Administrative Violation, \$500.00 fine per day, under Article 8308, Section 5.05 of the Texas Workers' Compensation Act.

General Information:

Name of Injured Employee: S.S.#:

Title / Occupation of Injured Employee:

Sex (circle one): M F Home Phone #: Date of Birth:

Race (circle one): White Black Asian Ethnicity (circle one): Hispanic Native American Other

Mailing Address (Street or P.O. Box):

City: State: ZIP Code:

Marital Status (circle one): Married Widowed Separated Single Divorced

Date of Injury: Time of Injury: am / pm (circle one)

Supervisor / Principal first knew of injury: Date: Time am / pm (circle one)

Name of Supervisor / Principal: Title:

Name of School or Location where accident occurred:

Address where accident occurred: (Street or P.O. Box):

City: State: ZIP Code:

Name of Witnesses:

Name of Witnesses:

Will the injured employee visit a doctor due to this injury? YES NO (circle one)

Name of doctor or location:

Address: (Street or P.O. Box):

City: State: ZIP Code:

Will the injured employee lose time from work due to this injury? YES NO (circle one)

If Yes, give the first day unable to work (date): Time: am / pm (circle one)

Return to work date or expected date:

NOTE: If the injured employee is visiting a doctor and / or losing time from work, the employee must present a doctors note (DWC Form 73 - Work Status Report) to the Risk Management Department

Risk Management

Supervisor / Principal Accident Investigation and Corrective Action:

Name of Injured Employee: _____ S.S.#: _____

Based on the investigation, the Supervisor / Principal shall describe how and why the accident occurred and state what the employee was doing when injured (i.e. unsafe act, unsafe conditions, etc.)

Supervisor / Principal shall indicate the employee's nature of injury (i.e. slip, fall, contusion, laceration, etc.)

Supervisor / Principal shall indicate the part of body injured or exposed (i.e. chin, right leg, forehead, etc.)

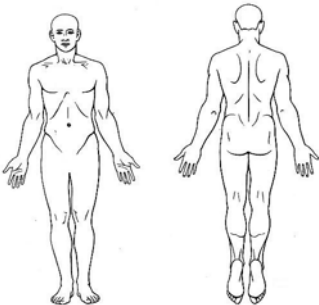
Supervisor / Principal shall describe corrective action to prevent reoccurrence of similar accidents. (i.e. safety training, prepare work order, etc.)

Employee's Statement and Injury Diagram:

(In your own words, describe in detail how the accident occurred and injuries sustained, if any) _____

(Circle exact area of body injured)

Provide additional information below or attach a separate page.



In order to process this claim, the **Supervisor / Principal** and **Employee** must sign below:

I, do hereby, authorize the El Paso Independent School District or its designee to release any information in my personnel records and obtain any medical records appropriate in the investigation of my claim.

Signature Supervisor/Principal as Witness

DATE

Signature of Injured Employee

DATE

NOTE: If the injured employee is visiting a doctor and / or losing time from work, the employee must present a doctors note (DWC Form 73 – Work Status Report) to the Risk Management Department