

Western Texas College Employee Injury Report

(form must be filled out and signed by the employee and supervisor at the time of injury)

Employee's Full Name

Last 4-digits of Social Security Number

Employee's Street Address

City, State Zip

Employee's Phone Number

Employee's Date of Birth

Department of Employment

Date of Hire

Location of Accident

Supervisor's Name

Date of Injury

Time of Injury

Describe in detail how the injury occurred:

What part of your body was injured? (please be specific)

Describe Injury :

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List Witnesses :

Will you be seeking medical treatment?

If yes, doctor or hospital name and location:

Date Lost time Began

I certify that the information contained in this report is true and correct.

I understand that any falsification of information regarding an on the job injury may result in disciplinary action and/or prosecution under the appropriate State Criminal Statutes.

I hereby authorize the release of all medical records related to the above noted incident to my employer, his agent or insurance company.

Employee's Signature

Employee's Printed Name

Date

I certify that the above employee has acknowledged to me that he/she understood all questions, signed and dated this form in my presence on this date.

Supervisor's/Witness' Signature

Supervisor's/Witness' Printed Name

Date
