	Medical Treatment Required		Report Only
	MUST Call Risk Management - 972-882-7375 or 972-882-5561		Rev. 05/2022

RISK MANAGEMENT **MUST** SEND AUTHORIZATION **PRIOR** TO MEDICAL TREATMENT

Employee Information: PLEASE P R I N T

Employee ID #		Campus/Bldg Assigned	

If injury did NOT occur at assigned campus/building, indicate site/address where injury occurred below

First Name		English Speaking?	
Last Name		If no, what language?	
Home Address 1		Birth Date MMDDYY	
Home Address 2		Gender	
City / Zip		Marital Status	
Phone		Job Title	
Work Phone		# of Dependents	
Employee Email			

Occurrence Information

Date of Injury/Illness MMDDYY		Body Part(s): Include Left/Right, Upper/Lower	
Time EE Began Work	Include AM or PM		
Time of Injury/Illness	Include AM or PM	Cause of Injury (trip/fall, tool, machinery, bite)	
Date Employer Notified			
Supervisor Name		Worksite Location of Injury (classroom, hallway, kitchen)	
Supervisor Phone #			
		Was Employee Doing their Regular Job?	

Treatmant Information

Workers' Comp Alliance Medical Provider			
Provider Address			
Provder Phone		Fax	
Witness Name		Witness Phone	
Employee Sign		**Date**	
Admin. Sign		**Date**	

RISK MANAGEMENT OFFICE USE ONLY - DO NOT WRITE BELOW

SSN		Hire Date		Hourly $		Daily $	
Weekly $		Weekly Hours		Campus #		Job Code	
Date Last Check		Amt. Last Check $		Annual Pay $			
Days Worked Yearly		Stipends					
Type of Injury							

ATTACH Detailed Written Statement: How Injury Occurred (Sequence of Events)