NUECES COUNTY RISK MANAGEMENT FORM RM01

901 Leopard, Room 523
Corpus Christi, Texas 78401

Employee's Initial Injury Report (First Report of Injury)

FAX (361)888-0403 / PHONE#: (361) 888-0401 ***Send Original via Inner Office Mail***

*This form must be completed "in detail," signed and provided to the supervisor by the injured employee as soon as possible after the incident -- **within 24 hours***

*(i.e., If incident occurs at end of day on Friday, employee "**must**" complete before going home)*

Your Full Name:	Marital Status: Single \ Married \ Divorced \ Separated \ Widowed
	Spouse's Name:
Social Security Number:	Department:
	Dept #:
Your Address (Street, City, State, Zip):	Supervisor's Name:
Work Phone: Home Phone:	Job Title at Time of Injury:
Date of Hire: Date of Birth:	Were you performing your normal duties? Yes or No
	How Long in Current Position? Years Months

Details of the Injury

Date of Injury:	**Time of Injury:** AM / PM	**Date you first Lost Time:**

Where in the workplace did your injury occur?

Address Where Injury Occurred:

Did this job require Safety Equipment? ☐ **Yes** ☐ **No**

If Personal Protective Equipment (PPE) was required, was it used ☐ **Yes** ☐ **No**

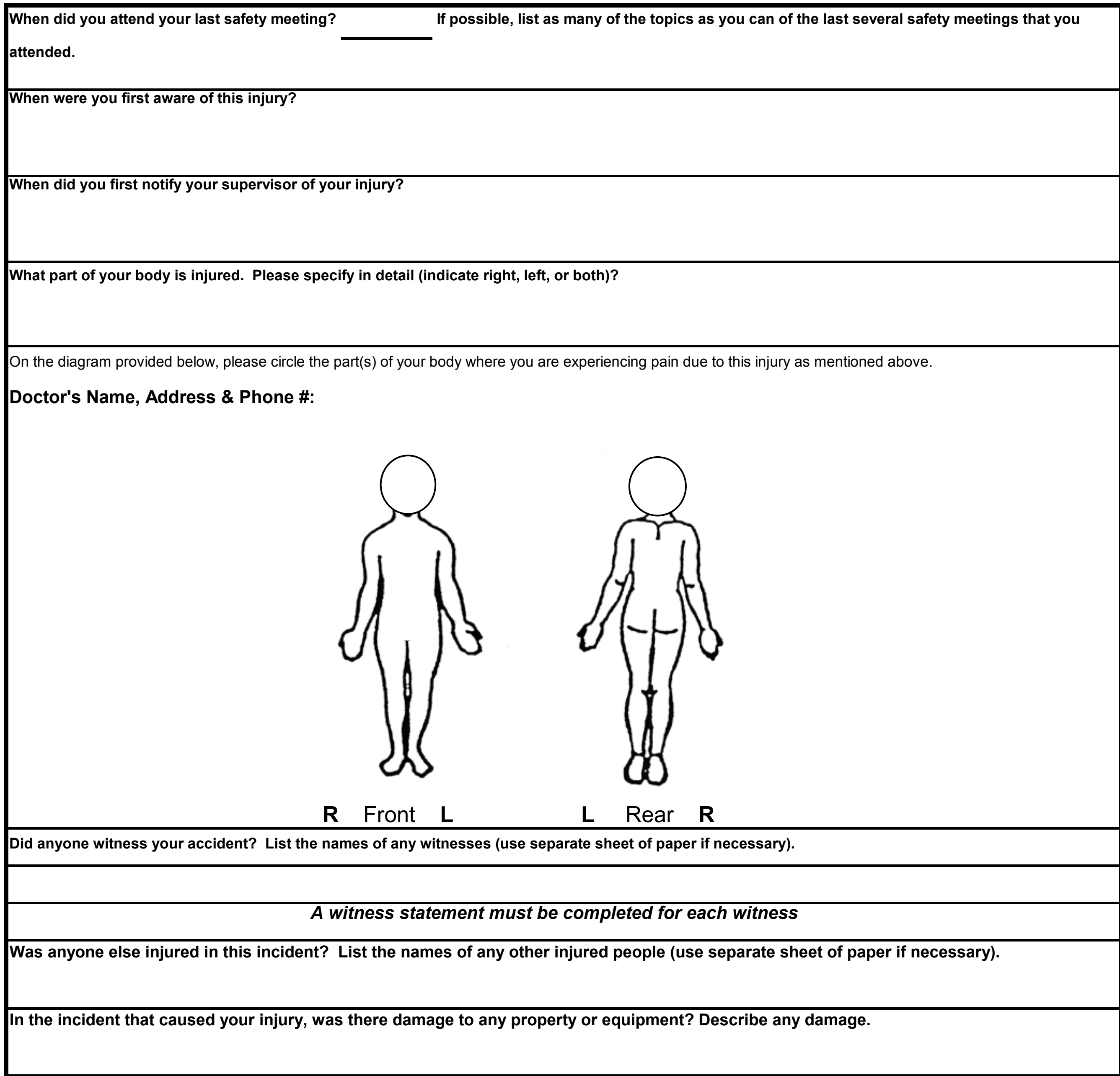
How did your injury happen? Describe in detail (use separate sheet of paper if necessary).

What safety equipment was being used at the time of the accident?

Was the cause of your injury due to human or machine error? ☐ Human ☐ Machine Error

In your opinion, what was the cause of your injury? (i.e. tool, fall, etc.):

What safety measures do you think can be taken to prevent an injury of this type in the future?



When did you attend your last safety meeting? ________ **If possible, list as many of the topics as you can of the last several safety meetings that you attended.**

When were you first aware of this injury?

When did you first notify your supervisor of your injury?

What part of your body is injured. Please specify in detail (indicate right, left, or both)?

On the diagram provided below, please circle the part(s) of your body where you are experiencing pain due to this injury as mentioned above.

Doctor's Name, Address & Phone #:

R Front **L** **L** Rear **R**

Did anyone witness your accident? List the names of any witnesses (use separate sheet of paper if necessary).

A witness statement must be completed for each witness

Was anyone else injured in this incident? List the names of any other injured people (use separate sheet of paper if necessary).

In the incident that caused your injury, was there damage to any property or equipment? Describe any damage.

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 relating to the above noted incident to my employer, his agent or insurance company.

Employee's Printed Name	Employee's Signature	Date

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