Texas A&M
University Health Services

uhs.tamu.edu | 979.458.4584

EMPLOYERS FIRST REPORT OF ILLNESS OR INJURY

Name (Last, First, M.I):		**UIN:**	**Date of Birth:**
Home Phone:		**Mailing Address:**	
Date of Injury:	**Time of Injury:** AM PM	**Date Lost Time Began:**	**Nature of Injury:**
Was employee doing his/her regular job?		**Part of body injured or exposed:**	
Worksite location of injury (stairs, office, clinic, etc.):		**Address where injury or exposure occurred (if not at UHS):**	
How and why injury/illness occurred:			
Cause of injury/illness (fall, tool, machine, etc.):			
List witnesses:			
Return to work date/or expected date:		**Date injury reported:**	
PRINT name and title of person completing form:		**SIGNATURE of person completing form:**	