# The University of Texas System

## Employee's First Report of Work-Related Injury or Endemic Illness

### Employee Information

Injured Employee's Name: _____ Male ☐ Female ☐ Date of Birth: ____/ ____/ _____

Home/Cell Phone: (_____) _____ Work Phone: (_____) _____ Preferred Language: _____

Personal Email Address: _____ Work Email Address: _____

Home Address: _____City: _____ State: _____ Zip: _____

Married ☐ Single ☐ Widowed ☐ Spouse's Name: _____ ☐ NA Number of dependent children? _____

Employing Institution: _____ Job Title: _____ Full Time ☐ / Part Time ☐

Department: _____ State/Country of Hire: _____ Country of Citizenship: _____

### Incident Information

City/Country/Location where occurrence happened (Please be specific) _____

Address/Description of location where occurrence happened (Please be specific)_____

Date of occurrence: _____ Time of occurrence: _____ ☐ AM ☐ PM Did you notify your supervisor? ☐ Yes ☐ No

Date Supervisor Notified: _____ Time _____ ☐ AM ☐ PM Name of Supervisor: _____

Were there any witnesses? ☐ Yes ☐ No Witness Name _____ Phone: (_____) _____

Did you seek medical treatment for this occurrence? ☐ Yes ☐ No If Yes, List name and address of hospital / physician below:

_____

Were days lost from work due to occurrence(not including injury date)? ☐ Yes ☐ No Have you returned to work*? ☐ Yes ☐ No

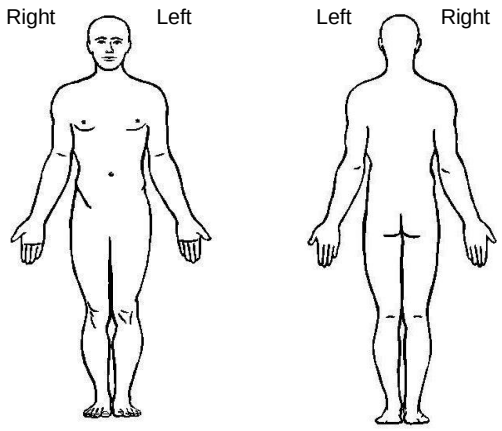
Date Returned to work*: ___/ ___/ _____ Trip Purpose/Work Performed: _____

***Return to work could include duties at UT institution as well as those assigned while abroad.**

**Please mark the areas of the body picture below that reflect where you were injured and check the appropriate boxes to the left.**

☐ Back
☐ Head
☐ Face
☐ Neck
☐ Shoulder
☐ Arm
☐ Wrist
☐ Hand
☐ Finger(s)
☐ Chest
☐ Abdomen
☐ Ribs
☐ Hips
☐ Buttocks
☐ Thigh
☐ Knee
☐ Leg
☐ Ankle
☐ Foot
☐ Other

***Front View*** ***Back View***




Describe in detail the nature of your injury or endemic illness and how it happened (if more space needed, write on back of sheet)

_____

_____

_____

_____

_____

_____

_____

_____

**The above statement is true and accurate to the best of my knowledge. I confirm that the occurrence described above happened while I was performing my essential job duties that were assigned to me by The University of Texas System Institution and my employing department.**

_____ _____ _____
Injured Employee's Signature Date Extension

_____ _____ _____
Supervisor's Signature Date Extension

**Please email the completed First Report of Injury to UT System at emataesquivel@utsystem.edu.**

# The University of Texas System Administration

## Workers' Compensation Network Acknowledgement Form

I have received information (Notice of Network Requirements & Employee Handbook Material) which informs me how to get Health Care under Workers' Compensation Insurance.

If I am hurt on the job and live in the service area described in this information, I understand that:

1. I must choose a treating doctor from the list of physicians in the ***IMO Med-Select Network®.*** (A list of physicians can be found at www.injurymanagement.com) Or, I may ask my HMO primary care physician to agree to serve as my treating doctor by completing the Selection of HMO Primary Care Physician as Workers' Compensation Treating Doctor Form # IMO MSN-5.
2. I must go to my network treating doctor for all health care for my injury. If I need a specialist, my treating doctor will refer me. If I need emergency care, I may go anywhere.
3. The insurance carrier will pay the treating doctor and other network providers.
4. I *may have to pay* the bill if I get health care from someone other than a network doctor without network approval.
5. If I receive the Notice of Network Requirements and refuse to sign the Acknowledgement Form, *I am still required to use the network*.

Please fill out the following information before signing and submitting this completed acknowledgement form. Injury Management Organization may contact you via phone, email and/or text to provide information to you and/or discuss your work injury.

**Name of Carrier:** The University of Texas System **Name of Network:** IMO Med-Select Network®

**Home Address**:_____

**Street Address – No P.O. Box or Work Address**

_____

**City** **State** **Zip Code** **County**

_____ _____ _____

**Printed Name** **Date of Injury** **Employee Phone Number**

_____ _____ _____

**Employee Signature** **Date** **Email**

For more information please contact the Office of Risk Management: Workers' Compensation Insurance at 512.499.4663

RxBridge

# THE UNIVERSITY OF TEXAS SYSTEM ADMINISTRATION
# FIRST FILL PRESCRIPTION CARD

Upon receiving prescriptions for a work-related injury for one of your employees, please provide the injured worker with a copy of this instruction sheet or ask them to text **UTS00** to toll free 833-FRSTFILL (833-377-8345). The injured worker will complete the process and then present their billing information via mobile device.

Please follow the below instructions to obtain your First Fill Prescription Card.

**Text**
**UTS00**
**to 833-377-8345**

## How it Works

**01**

**Text**
Text **UTS00** to toll free
833-FRSTFILL (833-377-8345)

**02**

**Follow the On-Screen Step by Step Instructions**
**Step 1:** Text your First and Last Name
**Step 2:** Text your Date of Injury
**Step 3:** Confirm Information

**03**

**Receive First Fill Card**
You will receive an image of your prescription card right to your phone.

**04**

**Fill Your Prescriptions**
Present your First Fill Prescription Card along with your injury related prescription(s) to your local pharmacy.


If you encounter any problems filling your prescriptions or to find a participating retail pharmacy, please call RxBridge at 833-RxBridge (833-792-7434) or use our pharmacy locator at www.RxBridge.com