

USSIC EMPLOYER REIMBURSEMENT

13403 Northwest Freeway, Houston, TX 77040



Please print or type form

FIRST REPORT OF INJURY

EMPLOYEE INFORMATION

Name		Gender	Email Address of Preparer		Social Security No(nnn-nn-nnnn)
Address		City	State	Zip	Phone
Date of Birth	Occupation	Department	Shift 1 st _____ 2 nd _____ 3 rd _____		Date of Hire

INJURY DETAILS

Date of Injury(mm/dd/yyyy)	Time of Injury (HH:MM)	Date Reported(mm/dd/yyyy)	Time Reported(HH:MM)
Address Where Injury Occurred			
Was Employee Doing Regular Job?		Supervisor Name	
Description of Accident			
Description of Injuries/Part of Body			
Cause of Injury (Tool, Fall, Machine, etc.)			
Did the Injury Require Medical Care?			
Name of Medical Provider	Address		Phone
Name of Witness	Address		Phone
Name of Witness	Address		Phone
Date Disability Began (mm/dd/yyyy)	Date Return to((mm/dd/yyyy)	Rate of Pay Hourly \$ Weekly \$	
Average Gross Weekly Wage (At least 12 weeks prior to accident, or number of weeks worked.)			

DOCUMENT ATTACHMENT (Required):

- 1) Signed Employee Acknowledgement of Summary Plan Description
- 2) Signed Authorization of Medical Treatment Document

POLICY INFORMATION

Employer Name	Policy #	Federal Tax Identification Number
Employer Address		Phone
Person Completing This Report		Date Completed (mm/dd/yyyy)

The employer agrees to make modified duty available for partially disabled employees able to return to some form of work as agreed to by their treating physician.

Employer Signature _____ Position _____

Fax complete form to 713 744-9675 or call 888 688-0775