



It's real.

This form is required within 24 hours of injury. Incomplete reports will be returned.

The City of Seguin  
First Report of Injury Form

HR Email:  
piuffredo@seguintexas.gov

Instructions: Injured employee must complete Section A & B. Supervisor or Manager must complete Section C & return form to Human Resources.

Date: \_\_\_\_\_

**Section A: Employee Information (Required by Texas Workers' Compensation Commission)**

Employee's Name: \_\_\_\_\_ Employee #: \_\_\_\_\_

Home Address: \_\_\_\_\_ County: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Age: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Marital Status: Married Single Divorced Separated Widow(er)

Spouse's Name: \_\_\_\_\_ Number of Dependent Children: \_\_\_\_\_

Date of Hire: \_\_\_\_\_ Job Title: \_\_\_\_\_

Department: \_\_\_\_\_ Supervisor's Name: \_\_\_\_\_

**Section B: Injury Information**

Date of Injury: \_\_\_\_\_ Time of Injury: \_\_\_\_\_ AM \_\_\_\_\_ PM

Body Part Injured: (Check Most Serious) Left: Right: Both:

_____ Ankle	_____ Eyes	_____ Head	_____ Neck	_____ Stomach
_____ Arm	_____ Face	_____ Knee	_____ Nose	_____ Thumb
_____ Back	_____ Feet	_____ Leg	_____ Shoulder	_____ Toe
_____ Chest	_____ Finger(s)	_____ Mouth	_____ Skin	_____ Wrist
_____ Elbow	_____ Hand	_____ Other: _____		

**Nature of Injury: (Check Most Appropriate)**

\_\_\_\_\_ Burn, scald, heat \_\_\_\_\_ Burn, chemical \_\_\_\_\_ Cut, laceration, puncture  
\_\_\_\_\_ Bruise, contusion \_\_\_\_\_ Inflammation, swelling \_\_\_\_\_ Irritation, rash  
\_\_\_\_\_ Sprain, strain \_\_\_\_\_ Other: \_\_\_\_\_

To whom did you report the injury to: \_\_\_\_\_ Date reported: \_\_\_\_\_

Did injury occur on City property? Yes: \_\_\_\_\_ No: \_\_\_\_\_ Address: \_\_\_\_\_

Was employee doing their regular job? Yes: \_\_\_\_\_ No: \_\_\_\_\_

How did injury occur: (Describe in detail):

**Section C: Supervisors Section:**

Witness to Injury: (Name) \_\_\_\_\_ Phone: \_\_\_\_\_

Personal Protective Equipment used? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Additional job training needed? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Was there an unsafe/hazardous condition? (i.e. wet floor) Yes: \_\_\_\_\_ No: \_\_\_\_\_

If Yes: \_\_\_\_\_

What immediate (short-term) action(s) have you taken to prevent a repeated accident? \_\_\_\_\_

\_\_\_\_\_

Did employee request medical attention? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If Yes, where: \_\_\_\_\_

Did employee return to work the day of injury after seeking medical treatment? Yes: \_\_\_\_\_ No: \_\_\_\_\_

***If medical attention is sought, a work release is required to return to work. Human Resources must authorize injury leave in advance of leave. Please contact Human Resources for further assistance.***

***Pina Iuffredo @ 830-386-2244 or 562-833-7459 after business hours & weekends***

To the best of my knowledge, I certify that all the information is complete and accurate.

Employee's Name; Signature: Date:

Supervisor's Name; Signature: Date:

Director's Name; Signature: Date: