ALAMO COLLEGES DISTRICT

ENTERPRISE RISK MANAGEMENT

Email completed form to:

ERM	dst-ERM@alamo.edu	
Jennifer Wilgen	jwilgen4@alamo.edu	210-485-0069
Mike Legg	mlegg2@alamo.edu	830-237-9934

☐ DIST ☐ SAC ☐ SPC ☐ SWC ☐ PAC ☐ NVC ☐ NLC ☐ Other:_____

EMPLOYEE INJURY REPORT

(to be completed by Injured Employee at the time of the injury unless emergency treatment is necessary)

NAME:			☐ M ☐ F
BANNER ID:	**SSN (last four only):**	**EMAIL:**	
HOME ADDRESS:			
CITY:	**STATE:**	**ZIP CODE:**	**COUNTY:**
WORK PHONE:	**HOME PHONE:**	**CELL PHONE:**	
JOB TITLE:	**DEPARTMENT:**	**SHIFT:** ☐ 1st ☐ 2nd ☐ 3rd	
SUPERVISOR:	**DATE REPORTED TO SUPERVISOR:**		
DATE OF INJURY:	**TIME OF INJURY:** ☐ AM ☐ PM		
SPECIFIC LOCATION OF ACCIDENT:			
PART(S) OF BODY INJURED:			
DESCRIBE HOW THE INJURY OCCURRED:			
WITNESS(ES) / NAME & PHONE #:			
DESCRIBE MEDICAL CARE PROVIDED:			
SIGNATURE OF INJURED EMPLOYEE:		**DATE:**	
SIGNED ON BEHALF OF INJURED EMPLOYEE: (in an emergency situation when Employee is unable to sign)		**DATE:**	
PRINTED NAME OF PERSON SIGNING ABOVE ON BEHALF OF EMPLOYEE:			
WAS 911 CALLED? ☐ **YES** ☐ **NO**	**WAS INJURED EMPLOYEE TRANSPORTED BY EMS?** ☐ **YES** ☐ **NO**		

THIS FORM DOES NOT CONSTITUTE ACCEPTANCE OF A WORKERS' COMPENSATION CLAIM.

TO REQUEST MEDICAL CARE UNDER ALAMO COLLEGES' SELF-FUNDED WORKERS' COMPENSATION PROGRAM OR FOR QUESTIONS ABOUT THIS REPORT, PLEASE CALL ENTERPRISE RISK MANAGEMENT (ERM) AT THE #s LISTED ABOVE. THE COMPLETED FORM MUST BE SENT BY EMAIL TO RISK MANAGEMENT AS SOON AS POSSIBLE. THE INJURED EMPLOYEE MUST PROVIDE A COPY OF THIS REPORT TO THE DEPARTMENT SUPERVISOR. **Revised: 07/26/2022**