

# FIRST REPORT OF INJURY – RANDOLPH FIELD ISD

## EMPLOYER GENERAL INFORMATION

Employer Name: Randolph Field ISD  
Street Address Line 1: Building 1225  
City, State, Zip: Randolph AFB , TX 78148-0000  
Mailing Address Line 1: PO Box 2217  
City, State, Zip: Universal City , TX 78148-2217  
Tax ID Number: 7460019-48  
Phone Number: 210-357-2300  
SIC Code: 611110

## EMPLOYEE INFORMATION

Employee Name (Last, First, MI)\*:

Street Address\*:

City, State, ZIP\*:  TX

Phone\*:  -  -

Date of Birth:

Social Security Number\*:

Sex\*:  Male  Female

Marital Status\*:  Unmarried  Married  Separated

Occupation/Job Title\*:

Employment Status\*:

# of Dependents:

Witness (Name & Phone #):

Date Administrator Notified:

Date Prepared:

Supervisor Name:

Supervisor Phone Number:  -  -

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## OCCURRENCE INFORMATION

Date of Injury/Illness

Time Employee Began Work

(example: 08:15)\*:

AM

PM

Time of Occurrence

(example: 08:15)\*:

AM

PM

Last Work Date

Type of Injury/Illness:

Part of Body Affected:

Cause of Injury:

Did injury/illness exposure occur on employer's premise?

Yes

No

Department or Location where accident or illness exposure occurred\*:

All equipment, material or chemicals employee was using when accident or illness exposure occurred:

Specify activity the employee was engaged in when the accident or illness exposure occurred\*:

Work process the employee was engaged in when accident or illness exposure occurred:

How injury or illness/abnormal health condition occurred. Describe the sequence of events and include any objects or substances that directly injured the employee or made the employee ill\*:

Date Returned to Work

Were Safeguards or Safety Equipment Provided?

Yes

No

Were they used?

Yes

No

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date