



The University of Texas
Health Science Center at San Antonio
Mail Code 7972
7703 Floyd Curl Drive
San Antonio, Texas 78229-3900
(210) 567-2590
(210) 567-6790 (Fax)

NOTIFICATION OF AN ON-THE-JOB INJURY

This form is to be presented to the Physician's Office, Hospital Emergency Room, or Pharmacy for treatment of an on-the-job injury.

TO: Medical Provider

This notice is to inform you that _____
(Employee Name)
in the department of _____, has claimed an on-the-
job injury and may be covered by Workers Compensation Insurance through the University of
Texas System. The University of Texas Health Science Center at San Antonio is a self funded
employer. Claims are processed through the University of Texas System Office in Austin. For
workers compensation consideration, please submit bills, medical reports, or questions to:

**The University of Texas System
114 West 7th Street, Ste. 600
Austin, Texas 78701
(512) 499-4675
1-888-396-6844
FAX (512) 499-4671**

Department Representative Signature

Date