Texas Department of Criminal Justice

Bryan Collier
Executive Director

Date Faxed: ______________

THE STATE OFFICE OF RISK MANAGEMENT
Workers' Compensation Division
Fax #: (512) 370-9025

Human Resources Headquarters
Fax #: (936) 437-4140

RE: NAME: ____

SSN: ____

DATE OF INJURY OR ILLNESS: _________________________

The original report for the above injury or illness is attached. Your office was initially notified by the Agency's Workers' Compensation department via entry into the SORM on-line system.

Sincerely,

____
Signature

Human Resources Representative: ____

Telephone: ____

Unit/Department Name: ____

Unit/Department Address: ____

Attachments:

cc: Unit or Department Medical File

(09/16)