

Medical Treatment Authorization
 SMU Office of Risk Management
 214.768.2807 · fax: 214.768.4138



Date and Time of Incident		Campus Location	
____ / ____ / ____ MM DD YYYY	_____ A.M / P.M. PLEASE CIRCLE	<input type="checkbox"/> SMU: Main Campus <input type="checkbox"/> SMU: East Campus	<input type="checkbox"/> SMU in Plano <input type="checkbox"/> SMU in Taos
Employee Information			
Employee Name: _____		DOB: ____ / ____ / ____ MM DD YYYY	
SMU Affiliation: _____		<input type="checkbox"/> Faculty	<input type="checkbox"/> Staff <input type="checkbox"/> Student
SSN: _____	Sex _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Employee Department: _____	Job Title: _____		
Manager or Supervisor: _____	Primary Phone: _____		
Nature of Injury:			