Supervisor's Incident/Injury Report

Division of Human Resources
Phone (813)974-5775 / Fax (813)974-7535 / SVC 2172

COMPLETE FORM WITHIN 24 HOURS OF INCIDENT and FORWARD TO:
WORKERS' COMPENSATION ADMINISTRATOR
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WC ADMINISTRATOR USE ONLY	
Date Received:	
GEMS Incident #	
GEMS Injury #	
GEMS Claim #	

INCIDENT DETAILS:

Date of Incident:	Time of Incident: _____ ☐ AM ☐ PM	Incident Location:
Injured Employee Name:	GEMS ID:	Is Location a Lab? ☐ Yes ☐ No
Incident Reported By:	☐ Injured Employee ☐ Injured Employees Supervisor ☐ Other USF Employee ☐ Other	

NOTE: If Incident was reported by "Other USF Employee" or "Other", please provide additional information below:

Reporter's Name	GEMS ID (If Applicable)	If Incident Reported by Non-Employee Provide	
		Phone	Address

LIST WITNESSES:

Witness Name	GEMS ID (If Applicable)	Witness's Contact Information	
		Phone	Address

INJURY DETAILS

Treatment Required:	☐ Medical Treatment ☐ First Aid ☐ Hospitalized ☐ None
If First Aid administered, provide details:	
Part(s) of Body Injured: Provide as much detail as possible. For example: Right Shoulder, Left Knee, etc.	

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Describe Nature of Injury: For Example: Burn, Bruise, Fracture, Laceration/Cut, Sprain, Strain etc.

INJURY DETAILS Continued

Cause or Type of Accident: For example (Burn/Scald from exposure to chemical OR Cut/Scrape by Broken Glass OR Fall from Ladder) ETC.

Provide a detailed statement of the incident and how it occurred:

MEDICAL DETAILS

Please check all that apply:

- ☐ Patient Taken to Hospital
- ☐ Fatal Injuries Sustained
- ☐ Resuscitation Required
- ☐ Ambulance Required
- ☐ Patient Fell Unconscious

Hours:

Minutes:

Supervisor Name (Print): _____ Telephone #: _____

Supv. GEMS ID #: _____

Supervisor Signature: _____ Date: _____