

SUPERVISOR'S ACCIDENT INVESTIGATION REPORT

TO BE COMPLETED BY THE SUPERVISOR AND FORWARDED TO THE WORKERS' COMPENSATION INSURANCE SPECIALIST IN HUMAN RESOURCES WITHIN 24 HOURS OF THE INCIDENT

USF DEPARTMENT _____

CAMPUS ADDRESS _____

1. Name of Injured: _____ GEMS ID# _____
2. Sex: M F Date of Birth: _____ Work Telephone #: _____
3. Date of Accident: _____ Time of Accident: _____ AM/PM
4. Employee's Job Title: _____ Length of Experience on Job: ____ (yrs) ____ (mos)
5. Location where Accident Occurred: _____ Is it a Laboratory? Yes No
6. Injury Type: **First Aid** (no medical treatment) **Medical** (medical treatment required)
7. If applicable, where was medical treatment sought? _____
8. Describe the Accident and how it occurred: _____

9. Describe the injury and part of body affected: (sprain, cut, burn, right, left, arm/foot) _____

10. Cause of the accident _____
11. Was Personal Protective Equipment required? Yes No Was it provided? Yes No
12. Was it being used? Yes No If "No" explain: _____

13. Was it being used as trained by supervisor or designated trainer? Yes No
If "No" explain _____
14. Safety Training provided to the injured? Yes No
If "Yes" date training was completed: _____ If "No" explain _____

15. List Witness(es): _____

16. Interim corrective actions taken to prevent recurrence: _____

Report Date: _____ Prepared by: (print) _____ Title _____

Supervisor Name (print) _____ Phone # _____

Supervisor Signature: _____ Date _____

TO BE COMPLETED BY SAFETY COORDINATOR

Status and follow-up action taken by Safety Coordinator: _____ _____ _____
Permanent corrective action recommended to prevent recurrence: _____ _____ _____
Safety Coordinator Signature: _____ Date _____

INJURIES OCCURRING AS A RESULT OF IMPROPER USE OF PERSONAL PROTECTIVE EQUIPMENT OR LACK OF TRAINING CAN RESULT IN A 25% REDUCTION IN YOUR WORKERS COMPENSATION BENEFITS.

MAIL FORM TO WORKERS' COMPENSATION, SVC 2172, OR FAX TO (813) 974-7535