DIVISION OF WORKER'S COMPENSATION ACCIDENT INVESTIGATION REPORT

TO BE COMPLETED BY THE SUPERVISOR AND FORWARDED TO SAFETY COORDINATOR IN EH&S WITHIN 24 HOURS OF THE ACCIDENT.

USF DEPARTMENT _____

CAMPUS ADDRESS _____

1. Name of Injured: _____ S.S.# _____
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)_____(mths)
5. Location where Accident Occurred: _____ Is it a Laboratory? ☐Yes ☐No
6. Injury Type: ☐ **First Aid** (did not seek medical treatment) ☐**Medical** (medical treatment was needed)
7. If Medical, where was 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. Witness(es): _____
16. Interim corrective actions taken to prevent recurrence: _____

    _____

Date of Report: _____ Prepared by: (print) _____ Title_____

Supervisor Name (Please 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 CRS 104 OR FAX TO (813) 974-9346