CBCS FACULTY AND STAFF - INCIDENT REPORT FORM FOR INJURY RELATED INCIDENTS:

Instructions:

- This form is to be completed by the supervisor and forwarded to the Worker's Compensation Insurance Specialist in Human Resources, SVC 2172 within 24 hours of the incident

- This form is only to be used for **INJURY** incidents involving faculty, staff and volunteers (who have completed all requisite paperwork).

- Please submit a COPY of this form to the Facilities Manager for review by the Dean's Office

USF UNIVERSITY OF SOUTH FLORIDA

Supervisor's Accident Investigation Report

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

TO BE COMPLETED BY THE SUPERVISOR AND FORWARDED TO THE WORKERS' COMPENSATION INSURANCE SPECIALIST IN HUMAN RESOURCES, SVC 2172 WITHIN 24 HOURS OF THE INCIDENT.

Name of Injured: _____ GEMS Employee ID #: _____

Job Title: _____ Department: _____

Length of experience on job: ____ (yrs) ____ (mos) Campus address: _____ Work Phone #: _____

Sex: ☐ Male ☐ Female Date of Birth: _____

Date of Accident: _____ Time of Accident: _____ ☐ AM ☐ PM

Accident Location: _____ Is it a laboratory? ☐ Yes ☐ No

Injury Type: ☐ **First Aid (no medical treatment)** ☐ **Medical (Medical treatment required)**

If applicable, where was medical treatment sought? _____

Describe the accident and how it occurred:

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

Cause of the accident:

Was Personal Protective Equipment required? ☐ Yes ☐ No Was it provided? ☐ Yes ☐ No

Was PPE being used? ☐ Yes ☐ No If "no" explain:

Was it being used as trained by supervisor or designated trainer? ☐ Yes ☐ No
If "No" explain:

Was safety training provided to the injured employee? ☐ Yes ☐ No If "Yes," date training was completed: _____

If "No," explain: _____

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List Witness(es): _____

Interim corrective actions taken to prevent recurrence:

Report Date: _____ Prepared by: _____ Title: _____

Supervisor Name (Print): _____ Telephone #: _____

Supervisor 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.

To be completed by Environmental Health and Safety:

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