



The University Of  
T A M P A

# FORM 1 - ACCIDENT/INCIDENT INVESTIGATION REPORT

*Please complete all information as applicable to the incident*

Name of Injured Employee/Student/Visitor:	Last Four Digits Social Security Number or Student/Employee ID:	Date of Birth:
Home Address:		Date & Time of Accident:
Location of Incident (please be specific):		
Nature of Injury	Describe Affected Body Parts:	Employer:
<input type="checkbox"/> First Aid:		<input type="checkbox"/> During Break
<input type="checkbox"/> Sent to Student Health Center		<input type="checkbox"/> Performing Work Duties
<input type="checkbox"/> Outside Emergency Care		<input type="checkbox"/> Working Overtime
<input type="checkbox"/> Fatality		<input type="checkbox"/> Entering or Leaving Work
		<input type="checkbox"/> Other
Department:	Manager:	Job Title:
Course Name:	Instructor:	
Treating First Responder:	Treating Physician:	Treating Emergency Facility:
Names of Witnesses:		
Supervisor at Time of Accident:	<input type="checkbox"/> Directly Supervised	<input type="checkbox"/> Indirectly Supervised
	<input type="checkbox"/> Not Supervised	<input type="checkbox"/> Supervision Not Feasible
Personal Account of How Incident Occurred:		
Signature:	Telephone:	Date
Witness Account of How Incident Occurred:		
Signature:	Telephone:	Date
Manager/Instructor Account of Incident		
Signature:	Telephone:	Date
<b>C O R R E C T I V E   A C T I O N S</b>		



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CASUAL FACTORS, EVENTS & CONDITIONS THAT CONTRIBUTED TO THE ACCIDENT:

CORRECTIVE ACTIONS: Those that have been or will be taken to prevent recurrence:

Date Due:

**UT HR or CHBO REVIEW**

Approved by:	Title:	Date
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