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:
☐ First Aid: ☐ Sent to Student Health Center ☐ Outside Emergency Care ☐ Fatality		☐ During Break ☐ Performing Work Duties ☐ Working Overtime ☐ Entering or Leaving Work ☐ Other
Department:	Manager:	Job Title:
Course Name:	Instructor:	
Treating First Responder:	Treating Physician:	Treating Emergency Facility:
Names of Witnesses:		
Supervisor at Time of Accident:	☐ Directly Supervised	☐ Indirectly Supervised
	☐ Not Supervised	☐ 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
CORRECTIVE ACTIONS		

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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 EHS REVIEW		
Approved by:	Title:	Date