FORM 1 - ACCIDENT/INCIDENT

INVESTIGATION REPORT

The University Of TAMPA

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:		
To Be Completed by Employee/Student/Visitor		
Personal Account of How Incident Occurred:		
Signature	Telephone:	Date

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Witness Account of Incident		
Witness Signature		Date
Manager/Instructor Account of Incident		
Manager/Instructor Signature		Date
Supervisor at Time of Accident:	☐ Directly Supervised	☐ Indirectly Supervised
	☐ Not Supervised	☐ Supervision Not Feasible
CORRECTIVE ACTIONS		
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
		Case Number: