

UWF Accident Investigation Form

Employee Name		Employee Number	Employee Job Classification/Position/Title
Department: <input type="checkbox"/> Admin Svcs <input type="checkbox"/> Wrk Ctrl <input type="checkbox"/> Bldg Svcs <input type="checkbox"/> Landscaping <input type="checkbox"/> Fac Maint <input type="checkbox"/> Utilities & Eng			
Area/Zone/Shop		Foreman/Supervisor	Phone
Date of Accident	Time of Accident	Location Where Accident Occurred (e.g., building, room, etc.)	
Describe the Accident			
Describe Activity Leading to Accident			
Conditions or Factors Contributing to the Accident (e.g., weather, visibility, poor housekeeping, etc.)			
Are written procedures available for the activity?		Was worker adequately trained for the activity?	
Were any special permits or authorizations needed? (list: e.g., hot work, confined space, asbestos, lead, etc.)			
Were proper procedure/controls being used? (list: e.g., machine guards, ventilation, HEPA vacuums, air monitoring, etc.)			
What personal protective equipment (PPE) was being used? (list: e.g., respirator, gloves, glasses, harness, etc.)			
Was any University property damaged?			
<u>Nature of Injury or Illness:</u> (check all that apply) <input type="checkbox"/> Sprain or Strain <input type="checkbox"/> Cut, Scrape or Puncture <input type="checkbox"/> Bruise or Contusion <input type="checkbox"/> Fracture <input type="checkbox"/> Dislocation or Joint Injury <input type="checkbox"/> Burn (chemical, thermal or solar) <input type="checkbox"/> Concussion or Head Trauma <input type="checkbox"/> Bite, Sting or Rash <input type="checkbox"/> Dermatitis or Skin Irritation <input type="checkbox"/> Exposure to Contaminant (chemical, biological radiological, etc.) <input type="checkbox"/> Other: _____			
<u>Type of Accident:</u> (Check all that apply. Check at least one bold item.) <input type="checkbox"/> Contact: <input type="checkbox"/> Struck By An Object <input type="checkbox"/> Struck Against An Object <input type="checkbox"/> Caught Between Objects or Inside an Object <input type="checkbox"/> Fall: <input type="checkbox"/> To Lower Level <input type="checkbox"/> To Same Level <input type="checkbox"/> Jump To Lower Level <input type="checkbox"/> Body Reaction or Exertion: <input type="checkbox"/> Lifting or Carrying <input type="checkbox"/> Pushing or Pulling <input type="checkbox"/> Repetitive Motion <input type="checkbox"/> Posture/Position <input type="checkbox"/> Exposure: <input type="checkbox"/> Electricity <input type="checkbox"/> Temperature <input type="checkbox"/> Pressure <input type="checkbox"/> Chemical <input type="checkbox"/> Radiation <input type="checkbox"/> Biological <input type="checkbox"/> Transportation: <input type="checkbox"/> Road Vehicle <input type="checkbox"/> Non-road Vehicle <input type="checkbox"/> Pedestrian <input type="checkbox"/> Other: _____ <input type="checkbox"/> Assault or Violence: <input type="checkbox"/> People <input type="checkbox"/> Animal <input type="checkbox"/> Other: _____ <input type="checkbox"/> Fire or Explosion <input type="checkbox"/> Other: _____			
<u>Body Part(s):</u> (Check all that apply. Check at least one bold item.) <input type="checkbox"/> Head: <input type="checkbox"/> Scalp or Skull <input type="checkbox"/> Eye(s) <input type="checkbox"/> Ear(s) <input type="checkbox"/> Mouth <input type="checkbox"/> Nose <input type="checkbox"/> Face <input type="checkbox"/> Neck: <input type="checkbox"/> Spine <input type="checkbox"/> Throat <input type="checkbox"/> Trunk: <input type="checkbox"/> Shoulder(s) <input type="checkbox"/> Back <input type="checkbox"/> Spine <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Hips(s)/Pelvis <input type="checkbox"/> Buttocks/Groin <input type="checkbox"/> Upper Extremities: <input type="checkbox"/> Upper Arm <input type="checkbox"/> Elbow <input type="checkbox"/> Lower Arm <input type="checkbox"/> Wrist <input type="checkbox"/> Hand <input type="checkbox"/> Finger(s) <input type="checkbox"/> Lower Extremities: <input type="checkbox"/> Upper Leg <input type="checkbox"/> Knee <input type="checkbox"/> Lower Leg <input type="checkbox"/> Ankle <input type="checkbox"/> Foot <input type="checkbox"/> Toes(s) <input type="checkbox"/> Body Systems: <input type="checkbox"/> Respiratory <input type="checkbox"/> Circulation <input type="checkbox"/> Nerves <input type="checkbox"/> Digestion <input type="checkbox"/> Skin <input type="checkbox"/> Hearing <input type="checkbox"/> Sight <input type="checkbox"/> Smell <input type="checkbox"/> Bones or Joints <input type="checkbox"/> Muscles <input type="checkbox"/> Reproductive System <input type="checkbox"/> Other: _____			
<u>Source of Injury or Illness:</u> (Check all that apply.) <input type="checkbox"/> Chemical(s) <input type="checkbox"/> Container(s) <input type="checkbox"/> Furniture or Fixture(s) <input type="checkbox"/> Machinery <input type="checkbox"/> Vehicle(s) <input type="checkbox"/> Parts or Material(s) <input type="checkbox"/> Person, Plant(s) or Animal(s) <input type="checkbox"/> Structure or Surface(s) <input type="checkbox"/> Tool(s), Instrument(s) or Equipment <input type="checkbox"/> Other: _____			
<u>Medical Treatment:</u> (Check all that apply.) <input type="checkbox"/> First Aid <input type="checkbox"/> Eye Wash or Shower <input type="checkbox"/> Medical Clinic <input type="checkbox"/> Emergency Room <input type="checkbox"/> Ambulance/Fire Dept. <input type="checkbox"/> Other: _____ <input type="checkbox"/> Admitted to Hospital <input type="checkbox"/> Scheduled for Return Medical Visit Diagnosis and/or Treatment Received: _____			
Final Determination of Cause			
New or Additional Preventive Measures to be Implemented			
Investigator Name		Investigator Signature	Date