UNIVERSITY OF MIAMI – INCIDENT/ACCIDENT FORM

To complete this form, please do the following:
1) Answer every question.
2) Requests marked with an (*) **must** be completed or the form will not be processed.
3) Use the **Digital Signature** feature to sign the form.
4) Press the **Submit** button to finish the process.

Please review our privacy statement (http://www.miami.edu/index.php/privacy_statement/) relating to gathering personal information before proceeding.

Employee/Injured Biographical Information

*Last Name: ________________ *First Name: ________________ Middle Initial: _______

*Email: ________________ *Social Security: ________________ *Sex: _______ *Date of Birth: ____________ *Age: _____

*Street Address: ________________ *City: ________________ *Zip Code: __________

Home Phone: ________________ Cell Phone: ________________

Employment Information

*Category: ________________ Department (Required for Employees): ________________

UM Job Title: ________________ Department Phone: ____________ Supervisor: ________________

Monthly Pay Rate: ___________ Hourly Pay Rate: ___________ Hours Worked/Week: ___________ Hired Date (mm/dd/yyyy): ________________

Accident/Incident General Information

*Date of Accident (mm/dd/yyyy): ________________ *Time (hh:mm): ____________ (_______)

*Location: ________________________________

*Date Reported (mm/dd/yyyy): ________________ Time Reported (hh:mm): ____________ (________)

To Whom Reported: ________________________________

Witness Name and Last Name: ________________________________

Address: ________________________________ Contact Phone Number: ________________

Second Witness Name and Last Name: ________________________________

Address: ________________________________ Contact Phone Number: ________________

Accident/Incident Detail Information

*Accident Category: ________________ *Accident Cause: ________________
NEEDLESTICK? Input Type: ________________ Other (Type): ____________ Brand: ________________
*Type of Injury: ________________ *Body Part Affected: ____________ __________ __________ Digits: ________

*Describe How the Accident Happened:

*Was Protective Equipment available to the Employee? Yes No N/A

*Was Protective Equipment being worn at the time of the Accident/Incident? Yes No N/A

*Was the Accident/Incident Preventable? Yes No

*Has Corrective Action been taken to prevent the Accident/Incident from recurring? Yes No

If YES, describe Action taken. If NO, explain why NO Action has been taken:

Aid and Treatment Information

*Was FIRST AID given? Yes No

Self-Administered? Yes No

Assisted by Someone Else? Yes No

By Whom?

*Did the Employee/Injured require Medical Treatment? Yes No

*Date of Treatment (mm/dd/yyyy): ________________ * Name of Treatment Facility: ____

*Did the Employee/Injured refuse Medical Treatment? Yes No

*No. of Working Days Missed: ____________ Date Returned to Work (mm/dd/yyyy): ____________________________

Signatures and Documentation

*Print Name of Injured Person: ____ *Date (mm/dd/yyyy): ______________

*Signature of Injured Person: ____

*Print Name of Supervisor: ____ Date (mm/dd/yyyy): ________________

*Signature of Supervisor: ____

Submission and Reporting

Failure to report Employee accidents/incidents to Risk Management within 24 Hrs may result in a fine by the State.

UM Risk Management
P.O. Box 248106
Coral Gables, FL 33124-1437
305-284-3163
305-284-3405 (Fax)