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) Sign and Fax to Risk Management: 305-284-3405

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 (Circle One):

1)	Full or Part time Employee	5)	Visitor/Guest	9)	Contractor
2)	Student Employee	6)	Wellness Center Member		
3)	Student	7)	Wellness Center Camper		
4)	Patient	8)	Per Diem		

Department (Required for Employees): _____ UM Job Title: _____

Department Phone: _____ Supervisor: _____ Hired Date (mm/dd/yyyy): _____

Monthly Pay Rate (Monthly Employees): _____ Hourly Pay Rate (Biweekly Employees): _____ Hours Worked/Week: _____

Accident/Incident General Information

*Date of Accident (mm/dd/yyyy): _____ *Time (hh:mm): _____ AM/PM (circle one)

*Location: _____

*Date Reported (mm/dd/yyyy): _____ Time Reported (hh:mm): _____ AM/PM (circle one)

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 (Circle Appropriate Description):

1)	LIFTING/PUSHING	8)	STRUCK BY MOVING OBJECT	15)	SLIP/TRIP	22)	FALL
2)	STRUCK BY FLYING OBJECT	9)	CONTACT W/PERSON/OBJECT	16)	NEEDLESTICK		
3)	CUT BY SHARP OBJECT	10)	BIOHAZARD CONTACT/EXPOSURE	17)	ELECTRICAL SHOCK		
4)	FOREIGN OBJECT IN EYE	11)	INFECTIOUS CONTACT/EXPOSURE	18)	ASSAULT		
5)	CONTACT W/HEAT/FLAME	12)	CHEMICAL CONTACT/EXPOSURE	19)	INHALATION		
6)	PUNCTURE W/SHARP OBJECT	13)	ANIMAL/INSECT BITE	20)	INGESTION		
7)	STRUCK BY FALLING OBJECT	14)	OVEREXTENSION	21)	AUTOMOBILE		

OTHER: _____

If Injury involves a NEEDLESTICK, please answer: Type (syringe, suture needle, etc.): _____ Brand Name: _____

*Accident Cause (Circle Appropriate Description):

1)	UNSAFE ACT	4)	FAULTY EQUIPMENT	7)	LACK OF ATTENTION	10)	USER ERROR
2)	UNSAFE CONDITION	5)	INHERENT RISK OF ACTIVITY	8)	IMPROPER TRAINING		
3)	ACT OF GOD	6)	UNDER INVESTIGATION	9)	MEDICAL CONDITION		

OTHER (Explain): _____

_____

*Type of Injury (Circle Appropriate Description):

1)	NONE	5)	RESPIRATORY	9)	CONTUSION	13)	SPLASH
2)	BITE	6)	BACK INJURY	10)	CONCUSSION	14)	BURN
3)	ELECTRIC SHOCK	7)	PUNCTURE	11)	FRACTURE	15)	FOREIGN BODY
4)	ABRASION/BRUISE	8)	LACERATION	12)	STRAIN/SPRAIN	16)	OTHER _____

***Body Part Affected**: _____ **Body Area** (Choose): 1) Left 3) Upper **Digits**: 1 2 3 4 5 NA
2) Right 4) Lower

*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: _____

*Signature of Injured Person: _____ Date (mm/dd/yyyy): _____

Print Name of Supervisor: _____

Signature of Supervisor: _____ Date (mm/dd/yyyy): _____

Submission and Reporting

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

Send Fax to: UM Risk Management
P.O. Box 248106
Coral Gables, FL 33124-1437
Off: 305-284-3163/Fax: 305-284-3405