

UNIVERSITY OF MIAMI – INCIDENT/ACCIDENT FORM

IN ORDER TO AVOID A DELAY IN FILING A WORKERS' COMPENSATION CLAIM PLEASE ANSWER EVERY QUESTION.
THIS IS A 3 PAGE FORM

Please review our privacy statement (<https://welcome.miami.edu/privacy-and-legal/index.html>) relating to gathering personal information before proceeding.

A: Injured Employee Biographical Information

Last Name: _____ First Name: _____ Middle Initial: _____
 Email: _____ Social Security: _____ Male Female Date of Birth: _____
FULL SSN REQUIRED
 Home Address: *(including City, State, Zip)*: _____
 Home Phone: _____ Cell Phone: _____

B: Employment Information

Category (Select One): Full or Part time Employee Visitor/Guest Contractor
 Student Employee Wellness Center Member
 Student Wellness Center Camper
 Patient Per Diem

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

Hours Work Per Day: _____	Hours Work Per Week: _____	Scheduled Work Days Per Week: S M T W Th F S	Wages Per Hour \$: _____ or Wages Per Month \$: _____
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C: Incident/Accident General Information

Date of Accident (mm/dd/yyyy): _____ Time (hh:mm): _____ AM PM Cannot be determined.
 Location of Incident/Accident: _____
(Example: 1 Main St., Miami, in the file room)

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

To Whom Reported: _____
REQUIRED - First & Last Name

Witness Name: _____ Contact Phone Number: _____
First & Last Name

Witness Name: _____ Contact Phone Number: _____
First & Last Name

D: Incident/Accident Detail Information

Accident Category (Select Appropriate Description):

- | | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|
| LIFTING/PUSHING
STRUCK BY FLYING OBJECT
CUT BY SHARP OBJECT
FOREIGN OBJECT IN EYE
CONTACT W/HEAT/FLAME
PUNCTURE W/SHARP OBJECT
STRUCK BY FALLING OBJECT | STRUCK BY MOVING OBJECT
CONTACT W/PERSON/OBJECT
BIOHAZARD
INFECTIOUS
CHEMICAL
ANIMAL/INSECT BITE
OVEREXTENSION | SLIP/TRIP Fall
NEEDLESTICK
ELECTRICAL SHOCK
ASSAULT
INHALATION
INGESTION
AUTOMOBILE |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------|

F: Supervisor/Manager Section

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: _____

Print Name of Supervisor: _____ Date (mm/dd/yyyy): _____

Signature of Supervisor: _____

G: Submission and Reporting

- 1) Use the **Digital Signature** feature to sign the form.
- 2) Press the **Submit** button to finish the process

IF ELECTRONIC SUBMISSION FAILS THIS FORM MAY BE PRINTED AND EMAILED
TO RISKMANAGEMENT@MIAMI.EDU OR FAXED TO 305-284-3405

Failure to report Employee accidents/incidents to Risk Management within 24 hours may result in a monetary fine imposed by the state of Florida Department of Financial Services.

University of Miami Risk Management Department
P.O. Box 248106 / Coral Gables, FL 33124-2945 / Main: 305-284-3163 – Fax: 305-284-3405