The University Of
TAMPA
401 W. Kennedy Blvd., Tampa, Florida 33606-1490 U.S.A.

Accident/Incident Investigation Report

Please complete all information as applicable to the incident

Name of Injured Employee/Student/Visitor:	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:	Phase of Workday at time of injury
☐ First Aid:		☐ During Break
☐ Sent to Student Health Center		☐ Performing Work Duties
☐ Outside Emergency Care		☐ Working Overtime
☐ Fatality		☐ 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:

Environmental Health & Safety Department		
Approved by:	Title:	Date
		Case Number: