UWF Accident Investigation Form

Employee Name	Employee Number	Employee Job Classification/Position/Title

Department: ☐ Admin Svcs ☐ Wrk Ctrl ☐ Bldg Svcs ☐ Landscaping ☐ Fac Maint ☐ 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?

Nature of Injury or Illness: (check all that apply)
☐ Sprain or Strain ☐ Cut, Scrape or Puncture ☐ Bruise or Contusion ☐ Fracture ☐ Dislocation or Joint Injury
☐ Burn (chemical, thermal or solar) ☐ Concussion or Head Trauma ☐ Bite, Sting or Rash ☐ Dermatitis or Skin Irritation
☐ Exposure to Contaminant (chemical, biological radiological, etc.) ☐ Other:____________________

Type of Accident: (Check all that apply. Check at least one bold item.)
☐ **Contact:** ☐ Struck By An Object ☐ Struck Against An Object ☐ Caught Between Objects or Inside an Object
☐ **Fall:** ☐ To Lower Level ☐ To Same Level ☐ Jump To Lower Level
☐ **Body Reaction or Exertion:** ☐ Lifting or Carrying ☐ Pushing or Pulling ☐ Repetitive Motion ☐ Posture/Position
☐ **Exposure:** ☐ Electricity ☐ Temperature ☐ Pressure ☐ Chemical ☐ Radiation ☐ Biological
☐ **Transportation:** ☐ Road Vehicle ☐ Non-road Vehicle ☐ Pedestrian ☐ Other:____________
☐ **Assault or Violence:** ☐ People ☐ Animal ☐ Other:____________ ☐ **Fire or Explosion** ☐ **Other:**__________

Body Part(s): (Check all that apply. Check at least one bold item.)
☐ **Head:** ☐ Scalp or Skull ☐ Eye(s) ☐ Ear(s) ☐ Mouth ☐ Nose ☐ Face ☐ **Neck:** ☐ Spine ☐ Throat
☐ **Trunk:** ☐ Shoulder(s) ☐ Back ☐ Spine ☐ Chest ☐ Abdomen ☐ Hips(s)/Pelvis ☐ Buttocks/Groin
☐ **Upper Extremities:** ☐ Upper Arm ☐ Elbow ☐ Lower Arm ☐ Wrist ☐ Hand ☐ Finger(s)
☐ **Lower Extremities:** ☐ Upper Leg ☐ Knee ☐ Lower Leg ☐ Ankle ☐ Foot ☐ Toes(s)
☐ **Body Systems:** ☐ Respiratory ☐ Circulation ☐ Nerves ☐ Digestion ☐ Skin ☐ Hearing ☐ Sight ☐ Smell
☐ Bones or Joints ☐ Muscles ☐ Reproductive System ☐ **Other:**____________________

Source of Injury or Illness: (Check all that apply.)
☐ Chemical(s) ☐ Container(s) ☐ Furniture or Fixture(s) ☐ Machinery ☐ Vehicle(s) ☐ Parts or Material(s)
☐ Person, Plant(s) or Animal(s) ☐ Structure or Surface(s) ☐ Tool(s), Instrument(s) or Equipment ☐ Other:__________

Medical Treatment: (Check all that apply.)
☐ First Aid ☐ Eye Wash or Shower ☐ Medical Clinic ☐ Emergency Room ☐ Ambulance/Fire Dept.
☐ Other:____________ ☐ Admitted to Hospital ☐ 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