UTD Accident Investigation FORMS

How To Use These Important Tools

Need Help?

If you would like assistance in setting up supervisory training on how to use these forms; or if you need additional copies please contact the EH&S at (972) 883-4111

Accident investigation forms/statements should be filled out by the injured UTD employee, UTD supervisor and any witness to the accident.

IMPORTANT - Obtaining signed statements as soon as possible following an accident insures that the employer has an accurate account of how the injury occurred, helps correct hazards to prevent the accident from recurring, and assures the employees claim is documented.

After I have these forms completed - what do I do with them?
UT System handles claim adjustments internally for injured UTD employees. After the injury is reported to the EH&S department, a representative from EH&S will contact the employee regarding case management of their injury.

What if my injured employee is physically unable to fill out the Employee’s Report of Injury?
Use common sense and good judgment. If the injury is severe - remember your employee’s health and care is first and foremost. If possible, have the form filled out at a later, more appropriate time when the employee is physically able to document the accident.

What if my Employee has retained an attorney - Can I still ask the injured employee to fill out an Employee's Report of Injury?
Yes - you, the employer as part of your company's accident management plan, can still ask the employee to fill out the report form.
Employee's Report of Injury

(To be completed by the employee only.)

Employee's name: _____________________________________________ Male__ Female__

Date of Birth:____/____/____ Home telephone #(______)_____________

Home address:___________________________________________________
City:_______________________ State:________ Zip Code:___________

Present Classification:______________________ How Long Employed at UTD:__________

Social security No.: _______ - _______ - ______ Weekly pay/salary: $____________

Location of accident:____________________________________________
(Address Area (loading dock, bathroom, etc.))

Date of accident:____/____/____ Time of accident:_________

Describe fully how accident occurred: (include events that occurred immediately before the accident):
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Describe bodily injury sustained (be specific about body part(s) affected):
____________________________________________________________________________
____________________________________________________________________________

Recommendation on how to prevent this accident from recurring:
____________________________________________________________________________
____________________________________________________________________________

Name of supervisor: _____________________________________________ Phone# (______)____________

Signature of Witness:___________________________________________ Date:____/____/____
Accident Witness Statement
(To be completed by accident witness)

Injured employee's name: _____________________________________________
Name of witness: _______________________________ Phone# (_____)________

Job title of witness: _______________________________ How long employed at UTD: ______
Home address of witness: _______________________________ State: ______ Zip Code: ______
City:______________________________________________
Location of accident:________________________________________________________________
(Adresse Area (loading dock, bathroom, etc.)
Date of accident: ____/____/____ Time of accident: _______
Whether Conditions: _______________________
Describe fully how accident occurred: (including events that occurred immediately before the accident):
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please indicate specifically which part(s) of the body were injured:__________________________
_______________________________________________________________________________

Recommendation on how to prevent this accident from recurring:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Name of supervisor: _______________________________ Phone# (_____)________
Signature of Witness: _______________________________ Date: ____/____/____
Was appropriate Personal Protective Equipment provided to employee? .........................Yes ___ No ___
Was employee trained in the appropriate use of PPE/Proper safety procedures? ..................Yes ___ No ___
Was employee cautioned for failure to use PPE/Proper safety procedures? .........................Yes ___ No ___
Did employee promptly report the injury/illness? .................................................................Yes ___ No ___
Is there modified duty available? .........................................................................................Yes ___ No ___

_________________________________________  ___________________________  __________  _______/
Supervisor's name  Supervisor's signature  Phone#  Date