Accident Investigation Forms  
— How to Use These Important Tools —

Accident investigation forms/statements should be filled out by the **injured UT Dallas employee**, **UT Dallas 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 UT Dallas 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.

**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: **Supervisor's Investigation**

— To be completed by the employee's supervisor or other responsible administrative official —

<table>
<thead>
<tr>
<th>Location where accident occurred:</th>
<th>□ No □ Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer's Premises:</td>
<td>□ No □ Yes</td>
</tr>
<tr>
<td>Job site:</td>
<td></td>
</tr>
<tr>
<td>Date of accident or illness:</td>
<td>/ /</td>
</tr>
<tr>
<td>Who was injured?</td>
<td></td>
</tr>
<tr>
<td>Time of accident:</td>
<td></td>
</tr>
<tr>
<td>Length of time with firm:</td>
<td></td>
</tr>
<tr>
<td>Job title or occupation:</td>
<td></td>
</tr>
<tr>
<td>Name of department normally assigned to:</td>
<td></td>
</tr>
<tr>
<td>How long has employee worked at job where injury or illness occurred?</td>
<td></td>
</tr>
<tr>
<td>What property/equipment was damaged?</td>
<td></td>
</tr>
<tr>
<td>Property/equipment owned by:</td>
<td></td>
</tr>
</tbody>
</table>

What was employee doing when injury/illness occurred? What machine or tool was being used? What type of operation?

How did injury/illness occur? List all objects and substances involved:

Part of body affected/injured?

Any prior physical conditions? □ No □ Yes — If so, what?

Nature and extent of injury/illness and property damaged (be specific):

- □ Improper instruction
- □ Lack of training or skill
- □ Operating without authority
- □ Horseplay
- □ Physical or mental impairment
- □ Failure to secure
- □ Failure to lockout
- □ Unsafe position
- □ Improper dress
- □ Improper protective equipment
- □ Unsafe equipment
- □ Poor housekeeping
- □ Unsafe arrangement or process
- □ Poor ventilation
- □ Improper guarding
- □ Improper maintenance
- □ Inoperative safety device
- □ Other: ________________

Supervisor's corrective action to ensure this type of accident does not recur:

Was appropriate Personal Protective Equipment provided to employee? □ No □ Yes
Was employee trained in the appropriate use of PPE/Proper safety procedures? □ No □ Yes
Was employee cautioned for failure to use PPE/Proper safety procedures? □ No □ Yes
Did employee promptly report the injury/illness? □ No □ Yes
Is there modified duty available? □ No □ Yes

Supervisor's name ____________________________ Supervisor's signature ____________________________ Phone Number ____________________________ Date / /
Injured employee’s name: ________________________________

Name of witness: ________________________________
Phone number of witness: ________________________________
Job title of witness: ________________________________
How long witness employed at UT Dallas: ________________________________

Home address of witness: ________________________________
City: ________________________________
State: ________________________________
ZIP Code: ________________________________

Location of accident: ________________________________
(loading dock, bathroom, etc...)

Date of accident: ______/_____/______
Time of accident: ________________________________
Weather 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:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Supervisor’s name ________________________________
Phone Number ________________________________

Employee’s signature ________________________________
Date ______/_____/______

The University of Texas at Dallas  — This document may be copied as needed —  Updated February 3, 2016
Environmental Health and Safety
800 W Campbell Rd, SG 10
Richardson, TX 75080-3021
Accident Investigation Forms: Employee's Report of Injury

— To be completed by the employee only —

Employee’s name: __________________________
Gender: __________________
Date of birth: _______ / _______ / _______
Home phone number: _______________________

Home address: __________________________________________________________
City: __________________________ State: __________________________ ZIP Code: __________

Present classification: ____________________________________________________
How long employed at UT Dallas: ____________________________________________
Social Security Number: __________________________
Weekly pay/salary: $ __________________________

Location of accident: _______________________________________________________
(loading dock, bathroom, etc…)

Date of accident: _______ / _______ / _______
Time of accident: __________________________

Describe fully how accident occurred (including 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:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Supervisor’s name ___________________ Phone Number _______________________
Employee’s signature ___________________ Date _______ / _______ / _______

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