

UTD Accident Investigation FORMS

How To Use These Important Tools

Includes:

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.

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



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: _____
Last, First Middle

Name of witness: _____ Phone# (____) _____

Job title of witness: _____ How long employed at

UTD: _____ Home address of witness: _____

City: _____ State: _____ Zip Code: _____

Location of accident: _____
(Address 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: ____/____/____

UTD Supervisor's Investigation

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

Location where accident occurred		Employer's Premises: Yes No Job site: Yes No		Date of accident or illness
Who was injured?		Employee Non-Employee		Time of accident a.m. p.m.
Length of time with firm	Job title or occupation	Name of dept. normally assigned to	How long has employee worked at job where injury or illness occurred?	
What property/equipment was damaged?			Property/equipment owned by:	
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? If so, what? Yes No				
Nature and extent of injury/illness and property damaged (be specific)				

- | | | |
|--|--|--|
| <input type="checkbox"/> Improper instruction | <input type="checkbox"/> Failure to lockout | <input type="checkbox"/> Unsafe arrangement or process |
| <input type="checkbox"/> Lack of training or skill | <input type="checkbox"/> Unsafe position | <input type="checkbox"/> Poor ventilation |
| <input type="checkbox"/> Operating without authority | <input type="checkbox"/> Improper dress | <input type="checkbox"/> Improper guarding |
| <input type="checkbox"/> Horseplay | <input type="checkbox"/> Improper protective equipment | <input type="checkbox"/> Improper maintenance |
| <input type="checkbox"/> Physical or mental impairment | <input type="checkbox"/> Unsafe equipment | <input type="checkbox"/> Inoperative safety device |
| <input type="checkbox"/> Failure to secure | <input type="checkbox"/> Poor housekeeping | <input type="checkbox"/> Other _____ |

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

- 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