



**THE UNIVERSITY OF TEXAS AT DALLAS
SAFETY OFFICE
ACCIDENT REPORT**



This form to be completed by supervisor immediately after accident and forwarded to: UTD Safety Office, Physical Plant, Mail Station: PP1.1 (Please use ball-point pen and press hard for easy reading.)

Report prepared by: Name _____ Ext. _____ Date _____

PERSONAL INFORMATION:

1. Name of injured/ill: _____ Home Phone: _____
2. Home address: _____
3. UTD Department: _____ Dept. Phone: _____
4. Title/Occupation: _____ Staff: _____ Student: _____ Visitor: _____
5. Time on present job: _____
6. Date of UTD employment: _____

ACCIDENT INFORMATION:

1. Date of accident: _____ Time: _____ a.m./p.m.
2. Location of accident: _____
3. Action taken: (a) sent to hospital: _____ (b) first aid _____ (c) returned to work _____
4. Name of doctor: _____ Address: _____
5. Name of hospital: _____ Address: _____
6. Nature of injury/illness: _____
7. Part of body affected: (i.e., left hand; right eye) _____
8. Lost time: No _____ Yes _____ First day unable to work: _____ Returned to work: _____

CAUSE FACTORS:

1. Causative agent most directly related to accident (object, substance, machinery, equipment, conditions): _____
2. Was weather a factor?: _____
3. Unsafe mechanical/physical/environmental condition at time of accident (be specific - MUST BE ANSWERED): _____
4. Unsafe act by injured and/or others contributing to the accident (be specific - MUST BE ANSWERED): _____
5. Personal factors (improper attitude, lack of knowledge or skill, slow reaction, fatigue, horseplay, etc.) _____
6. Personal protective equipment required (eye protection, protective clothing, respiratory, safety hats, etc.): _____
7. Was injured person using required equipment? _____ If not, give reason: _____
8. Date and subject of injured employee's last safety meeting: _____
9. Did the injured person receive STA (Safety Task Assignments) for the job? _____

PREVENTION INFORMATION:

1. What can be done to prevent a recurrence of this type of accident/incident? (modification of equipment, mechanical guards, safety operating procedure, correct environment, training, etc.): _____

SUPERVISOR'S STATEMENT: (use additional sheets if required)

1. Detailed narrative description (how did accident occur, why?, objects, equipment tools used, circumstances, assigned duties, etc. - be specific) _____
2. Witnesses to accident: _____

Signature of Supervisor: _____ Department: _____ Date: _____

SAFETY ENGINEER'S STATEMENT: (use additional sheets if required)

1. Evaluation of accident and recommended corrective action: _____

Signature of Safety Officer: _____ Date: _____

COMMENTS OF DIRECTOR/DEPARTMENT HEAD: _____

Signature of Director/Dept. Head: _____ Date: _____