UNIVERSITY OF MIAMI – INCIDENT/ACCIDENT FORM

IN ORDER TO AVOID A DELAY IN FILING A WORKERS' COMPENSATION CLAIM PLEASE ANSWER EVERY QUESTION.
THIS IS A 3 PAGE FORM

Please review our privacy statement (https://welcome.miami.edu/privacy-and-legal/index.html) relating to gathering personal information before proceeding.

A: Injured Employee Biographical Information

Last Name: _____ First Name: _____ Middle Initial: _____

Email: _____ Social Security: _____ ☐ Male ☐ Female Date of Birth: _____
FULL SSN REQUIRED

Home Address: (*including City, State, Zip*): _____

Home Phone: _____ Cell Phone: _____

B: Employment Information

Category (Select One):

☐ Full or Part time Employee
☐ Student Employee
☐ Student
☐ Patient
☐ Visitor/Guest
☐ Wellness Center Member
☐ Wellness Center Camper
☐ Per Diem
☐ Contractor

Department: _____ Department Phone: _____

UM Job Title: _____ Supervisor: _____ Date Hired (mm/dd/yyyy): _____

Hours Work Per Day:_____	Hours Work Per Week:_____	Scheduled Work Days Per Week: S☐ M☐ T☐ W☐ Th☐ F☐ S☐	Wages Per Hour $:_____ *or* Wages Per Month $:_____

C: Incident/Accident General Information

Date of Accident (mm/dd/yyyy): _____ Time (hh:mm): _____ AM☐ PM☐ Cannot be determined☐

Location of Incident/Accident: _____
(*Example: 1 Main St., Miami, in the file room*):

Date Reported (mm/dd/yyyy): _____ Time Reported (hh:mm): _____ AM☐ PM☐

To Whom Reported: _____
REQUIRED - *First & Last Name*

Witness Name: _____ Contact Phone Number: _____
First & Last Name

Witness Name: _____ Contact Phone Number: _____
First & Las Name

D: Incident/Accident Detail Information

Accident Category (Select Appropriate Description):

☐ LIFTING/PUSHING
☐ STRUCK BY FLYING OBJECT
☐ CUT BY SHARP OBJECT
☐ FOREIGN OBJECT IN EYE
☐ CONTACT W/HEAT/FLAME
☐ PUNCTURE W/SHARP OBJECT
☐ STRUCK BY FALLING OBJECT
☐ STRUCK BY MOVING OBJECT
☐ CONTACT W/PERSON/OBJECT
☐ BIOHAZARD
☐ INFECTIOUS
☐ CHEMICAL
☐ ANIMAL/INSECT BITE
☐ OVEREXTENSION
☐ SLIP/TRIP ☐ Fall
☐ NEEDLESTICK
☐ ELECTRICAL SHOCK
☐ ASSAULT
☐ INHALATION
☐ INGESTION
☐ AUTOMOBILE

OTHER (Explain):

_____

_____

If injury involves a NEEDLE STICK, please answer: Type (syringe, suture needle, etc.): _____ Brand Name: _____

Accident Cause (Select Appropriate Description):

☐ UNSAFE ACT	☐ FAULTY EQUIPMENT	☐ LACK OF ATTENTION	☐ USER ERROR
☐ UNSAFE CONDITION	☐ INHERENT RISK OF ACTIVITY	☐ IMPROPER TRAINING	
☐ ACT OF GOD	☐ UNDER INVESTIGATION	☐ MEDICAL CONDITION	

OTHER (Explain): _____

_____

Type of Injury (Select Appropriate Description):

☐ ABRASION/BRUISE	☐ CONCUSSION	☐ FOREIGN BODY	☐ SPLASH
☐ BACK INJURY	☐ CONTUSION	☐ LACERATION	☐ STRAIN/SPRAIN
☐ BITE	☐ FRACTURE	☐ PUNCTURE	☐ OTHER
☐ BURN	☐ ELECTRIC SHOCK	☐ RESPIRATORY	

OTHER (Explain): _____

_____

Body Part(s) Injured: _____

Body Area (Choose): Left ☐ Upper ☐ **Digits**: 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ NA ☐

Right ☐ Middle ☐

Lower ☐

Describe How the Accident Happened:

_____

_____

_____

Medical Treatment

Was FIRST AID given? Yes ☐ No ☐

Self-Administered? Yes ☐ No ☐

Assisted by Someone Else? Yes ☐ No ☐

By Whom? _____

Did the Employee/Injured require Medical Treatment? Yes ☐ No ☐

Date of Treatment (mm/dd/yyyy): _____ Name of Treatment Facility: _____

Did the Employee/Injured refuse Medical Treatment? Yes ☐ No ☐

No. of Working Days Missed: _____ Date Returned to Work (mm/dd/yyyy): _____

E: Employee Signature

Print Name: _____ Signature: _____ Date (mm/dd/yyyy): _____

F: Supervisor/Manager Section

Was Protective Equipment available to the Employee? Yes ☐ No ☐ N/A ☐

Was Protective Equipment being worn at the time of the Accident/Incident? Yes ☐ No ☐ N/A ☐

Was the Accident/Incident Preventable? Yes ☐ No ☐

Has Corrective action been taken to prevent the Accident/Incident from recurring? Yes ☐ No ☐

If YES, describe action taken. If NO, explain why NO Action has been taken: _____

Print Name of Supervisor: _____ Date (mm/dd/yyyy): _____

Signature of Supervisor: _____

G: Submission and Reporting

1) Use the **Digital Signature** feature to sign the form.
2) Press the **Submit** button to finish the process

Submit **Clear**

IF ELECTRONIC SUBMISSION FAILS THIS FORM MAY BE PRINTED AND EMAILED TO RISKMANAGMENT@MIAMI.EDU OR FAXED TO 305-284-3405

Failure to report Employee accidents/incidents to Risk Management within 24 hours may result in a monetary fine imposed by the state of Florida Department of Financial Services.

University of Miami Risk Management Department
P.O. Box 248106 / Coral Gables, FL 33124-2945 / Main: 305-284-3163 – Fax: 305-284-3405