University of Houston DOWNTOWN

Supervisor's Report of Accident

This form must be completed within 24 hours of the accident

Employee's Name _____ Full/Part Time _____ Gender _____

Job Position/Title _____ Department _____

Supervisor's Name _____ Supervisor's Phone # _____

Date of Accident _____ Time of Accident _____

Location of Accident _____

On Campus? ◯ Yes ◯ No Regular Occupation When Injured? ◯ Yes ◯ No

Task(s) Being Performed When Accident Occurred _____

Date Employee Reported Accident To You _____ Time Employee Reported Accident _____

Name(s) of Witness(es) _____

Accident Resulted in: ☐ Injury: Body Part Injured _____

First Aid Given? ◯ Yes ◯ No Medical Treatment Required? ◯ Yes ◯ No

Workdays Lost _____

☐ Property Damage

☐ Fatality

Employee's Account of Accident (as related to you)

Describe any unsafe acts or conditions that may have contributed to this accident

Prior to this accident, were any incidents or near-misses reported? If yes, please describe the incidents and the dates they were reported.

What actions have been taken to prevent recurrence?

If lifting injury, what was the employee lifting? _____

Weight of object _____ To what height was employee lifting object? _____

Supervisor's Comments (Procedures, equipment, etc)

_____ _____ _____

Supervisor's Printed Name Signature of Supervisor Date

Please return a copy of this form to Eddie Arias at AriasE@uhd.edu and Erica Morales at MoralesE@uhd.edu

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