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Florida Agricultural and Mechanical University

TALLAHASSEE, FLORIDA 32307–3100

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**Office of Risk Management**

#  FAMU EMPLOYEE

# ACCIDENT INVESTIGATION REPORT

This form must be completed by the **SUPERVISOR** of the injured employee. Your investigation should be thorough so it can be determined if the accident occurred as a result of an **unsafe act**, an **unsafe condition**, or **employee negligence**.

 **(Please Print)**

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| --- |
| 1. **EMPLOYEE:**
 |
| 1. **Job Title**:
 |
|  **Job Class**:  |  **Dept**: |
|   Supervisor |
| b) Date of accident  |
|   Time of accident: | AM | PM |
|   c) Witnesses : 1) |
|   2) |
| 1. Employee Injury:
 |
| 1. Accident Location:
 |
| 4) **\*\*DESCRIBE HOW THE ACCIDENT OCCURRED**: |
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|  |
| a) Was injury work related? | YES | NO |
| b) Was medical treatment available? | YES | NO |
| c) Was medical treatment received? | YES | NO |
| d) Medical treatment facility: |
| e) Was protective safety equipment available? | YES | NO |
| f ) Was protective safety equipment used? | YES | NO |

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|  |  |  |
| --- | --- | --- |
| 6) Was the injury due to an unsafe condition? | YES | NO |
| a) If the answer is yes, explain the hazardous condition and what has been done to  remove or correct the condition. |
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|  |
| 1. Was the injury due to an unsafe act?
 | YES  | NO |
| 1. If the answer is yes, explain the situation and indicate if training is available

 to correct this behavior. |
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|  |
| 1. Does the injured employee have a recommendation to prevent the accident from happening again?
 | YES | NO |
|  If yes, explain. |
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|   |
| 1. Does the supervisor agree with the recommendation?
 | YES | NO |
| 1. What resources are necessary to implement the recommendation or explain

why the recommendation cannot be implemented. |
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| 10) If other details or remarks are applicable, please indicate in the area provided? |
|  |
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| This form should be sent to the **Risk Management at POM Bld. - Suite 125** immediately upon completion. We can be reached by fax at (**599-8024**) |
|  |
| **Supervisor’s signature & phone number**: |
| **Employee’s signature**: |
| **Date**: |
| **Note**:If the employee is not available for signature, indicate so on your report.  The employee shall be aware of the supervisor’s comments. |

\*\*ATTACH SEPARTE PAGE(S) IF ADDITIONAL SPACE IS NEEDED TO DESCRIBE HOW THE ACCIDENT OCCURRED

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