

**FLORIDA TECH**

**EMPLOYEE ACCIDENT / INJURY REPORT**

Contact Financial Affairs @ 674-7340 OR 7297 IMMEDIATELY regarding an Employee's Injury.  
**Employee AND Supervisor must complete this report.**

**EMPLOYEE INFORMATION** Please Print Clearly:

NAME: SOCIAL SECURITY#:

EMPLOYEE ID#: DATE OF BIRTH:

DATE OF INCIDENT: TIME OF INCIDENT:

DATE OF HIRE: JOB TITLE:

HOME ADDRESS:(If PO Box list physical address as well.)

HOME PHONE NUMBER: CELL PHONE #:

WORK PHONE NUMBER: SUPERVISOR:

MARITAL STATUS: # OF DEPENDENTS:

FULL TIME OR PART TIME SALARY/HRLY WAGE:

**ACCIDENT INFORMATION**

PART OF BODY INJURED:

WHAT WERE YOU DOING WHEN INJURED:(COMPLETE DESCRIPTION)

NAME OF TOOLS,EQUIPMENT OR HAZARDOUS MATERIAL IN USE AT THE TIME:

LOCATION OF INCIDENT:

LIST WITNESSES:

WHAT TIME DID YOU START YOUR WORK DAY?

Do you feel your injury/illness is directly related to work? YES ( ) NO ( )

EMPLOYEE SIGNATURE: DATE:

Any person who, knowingly and with intent to injure, defraud, or deceive any employer, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in s. 817.234, Section 440.105(7), F.S.

*MEDICAL CARE PROVIDERS ARE ASSIGNED TO YOU IF YOU ARE INJURED ON THE JOB. IT IS YOUR RESPONSIBILITY TO NOTIFY US IF YOU WANT MEDICAL ATTN.*

**TO BE COMPLETED BY SUPERVISOR:**

Do you agree with the description of the incident?

What corrective actions will take place to prevent future incidents?

SUPERVISORS SIGNATURE: DATE:

**LIST ALL WITNESSES \* ATTACH STATEMENTS**

\*Root Cause Analysis or Motor Vehicle Accident Investigation may be required as follow up.