

ASU SUPERVISOR'S ACCIDENT/ILLNESS INVESTIGATION FORM

Return to: University Safety Office/PO Box 32112, Business Affairs Annex

This form is to be forwarded to the Safety Office within 24 hours or as soon as possible of the accident/illness.

IMMEDIATELY report all accidents involving serious bodily injury or death to the Safety Office (X 4008)

ACCIDENT DATA

ACCIDENT DATA		
1. Name of Employee:	SS#:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female
2. Home Address and Phone No.		
3. Work Dept. or Office:	4. Date and Time of Injury	5. Date Employer Notified
6. Nature of Injury:	7. Part of body Injured:	
8. Cause of Injury:	9. Location of Accident:	
10. Job/Activity Being Performed at Time of Accident:	11. Status of Job or Activity: (Check one) Halted Continuing Completed	
12. Brief Description of Accident:		
13. Name and Phone No. of Accident Witness:		
14. List Unsafe Act, if any:		
15. List Unsafe Physical or Mechanical condition, if any:		
16. Any Other Unsafe Factors:		
17. List Hazard Controls in effect at time of Injury Designed to Prevent Injury:		
18. Personal Protective Equipment Being Used at Time of Accident: (gloves, safety glasses, goggles, face shield, other)		
19. Corrective Action Taken or Recommended:		
20. Printed Name of Supervisor:		
Signature:	Date:	Phone:
21. Printed Name of Department Director and/or Chairperson:		
Signature:	Date:	Phone: