Employee Injury Incident Report

Developmental Research School
at the University of Florida

Date of Incident______________ Time of Incident ____________ AM/PM

Reported by ____

Employee Legal Name – Last______________________ First______________________ Middle______________

Title/Position ______________________ UFID No. __________________Supervisor ________________________

Type of Injury ☐Medical ☐Physical Location Where Injury Occurred________________________________

Nature of Injury ____

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Incident Involved Student(s) ☐No ☐Yes Name(s)______________________________________

UF Worker's Compensation Office contacted within one (1) hour?

☐No ☐Yes – Time ________________ Phone: 352.392.4940

Action Taken

☐School Clinic/Nurse ☐First Aid ☐On-campus Treatment ☐ CPR/AED ☐EMS/911 ☐Other

Description of Incident____

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Witnesses

______________________ ______________________ ______________________

Notification Made to ☐Parent/Guardian ☐Emergency Contact ☐Administrator ☐Nurse

Name of Person Contacted ______________________________________ by Time ____________

Administrator Notified ______________________________________by Time ____________

Employee Statement ____

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Employee Signature ______________________________________ Date ______________

Administrator Signature ______________________________________ Date ______________

Prevention – Describe corrective actions indicated to prevent recurrence

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Copies to Director, Administrator/Principal, and Business Services

1080 SW 11th Street Gainesville, FL 32601

P: 352.392.1554 ■ F: 352.392.9559 ■ pkyonge.ufl.edu