USF UNIVERSITY OF SOUTH FLORIDA

Supervisor's Incident/Injury Report

Department of Environmental Health & Safety

Phone (813)974-5775 / Fax (813)974-7535 / OPM100

COMPLETE FORM WITHIN 24 HOURS OF INCIDENT and FORWARD TO:
WORKERS’ COMPENSATION ADMINISTRATOR
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WC ADMINISTRATOR USE ONLY	
Date Received:	
GEMS Incident #	
GEMS Injury #	
GEMS Claim #	

INCIDENT DETAILS:

Date of Incident:	Time of Incident: ______ ☐ AM ☐ PM		Injured Employee's Department Mailstop:
Injured Employee Name:		GEMS ID:	
Incident Location:			Is Location a Lab? ☐ Yes ☐ No

NOTE: If Incident was reported by “Other USF Employee” or “Other”, please provide additional information below:

Incident Reporter’s Name	GEMS ID (If Applicable)	If Incident Reported by Non-Employee Provide	
		Phone	Address

LIST WITNESSES:

Witness Name	GEMS ID (If Applicable)	Witness’s Contact Information	
		Phone	Address

INJURY DETAILS

Treatment Required:	☐ Medical Treatment ☐ First Aid ☐ Hospitalized ☐ None

If First Aid administered, provide details:

Part(s) of Body Injured: Provide as much detail as possible. For example: Right Shoulder, Left Knee, etc.

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Describe Nature of Injury: For Example: Burn, Bruise, Fracture, Laceration/Cut, Sprain, Strain etc.

INCIDENT DETAILS

Provide a detailed statement of the incident and how it occurred:

Corrective action recommended to prevent recurrence:

MEDICAL DETAILS

Please check all that apply:

- ☐ Patient Taken to Hospital
- ☐ Fatal Injuries Sustained
- ☐ Resuscitation Required
- ☐ Ambulance Required
- ☐ Patient Fell Unconscious
  - Hours:
  - Minutes:

Supervisor Name (Print): ____________________

Telephone #: ____________________

Supv. GEMS ID #: ____________________

Supervisor Signature: ____________________

Date: ____________________

Notice to Injured Employee: I affirm with my signature below that I have reviewed, understand, and acknowledge the above statements are true. In addition, I am aware that any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information commits insurance fraud, punishable as provided in Sections 817.234 and 440.105(7) per Florida Statutes.

Injured Employee Name (Print): ____________________

Telephone #: ____________________

Injured Employee Signature (if available): ____________________

Date: ____________________