Office of Risk Management

First report of Accident/Incident

Event No: ______________________________
Claim No: ______________________________

Date of Incident: _____/_____/______
Time of Incident: ___________ a.m. p.m.
Date Reported: _____/_____/_____

____

Incident Type:
☐ Personal Injury/Illness
☐ Property Damage
☐ Vehicle Accident
☐ Other: ___________________

Personnel Information:
Last Name: ____________________________ First Name: ____________________ MI: __________
Social Sec. No: ______-____-________ Date of Birth (mm-dd-yy): ____/_____/______ Sex: ☐ M ☐ F
Home Address:_______________________________________ Home Phone: (___)___________________
City: _______________ State: _____ ZIP: _________ Work Phone: (___)____________________

Affiliation:
☐ Staff/Faculty ☐ Non – SMU ☐ Student Department: _____________________________
Job Title: ________________________________ Manager or Supervisor: _____________________________

Campus Location: ☐ Main Campus – Dallas ☐ SMU – Legacy ☐ SMU – In – Taos
☐ Off – Campus: ____

Incident Summary (Provide a detailed description of the accident – attach additional pages if necessary):

____
____
____
____
____
____

I hereby certify that the above information is true and correct to my understanding of the incident.

________________________	________________________	________________________
Print Name	***Signature***	***Date***

Witness Name(s)	Business Phone	Home Phone
______________________________	(____)__________________	(____)__________________
______________________________	(____)__________________	(____)__________________
______________________________	(____)__________________	(____)__________________

This Section for Risk Management/EH&S Use Only

Classification: ☐ First Aid ☐ OSHA Injury ☐ OSHA Illness ☐ Non-Occupational ☐ Fatality OSHA Recordable: ☐ Yes ☐ No

Incident Type:	Injury Type:	Body Part:	Illness Type:
☐ Slip/Trip/Fall	☐ Abrasion	☐ Eye(s) – L/R	☐ Occ Skin Disorder
☐ Struck By/Against	☐ Contusion	☐ Head/Neck	☐ Dust Disease- Lungs
☐ Caught In/Between	☐ Laceration	☐ Arm(s)/Wrist(s) – L/R	☐ Respiratory- Toxic Agent
☐ Overexertion	☐ Puncture	☐ Hand(s)/Finger(s) – L/R	☐ Systemic Poisoning
☐ Repetitive	☐ Strain/Sprain	☐ Back	☐ Disorders- Physical Agents
☐ Foreign Body	☐ Fracture	☐ Trunk	☐ Disorders-Repetitive Trauma
☐ Hand Tool/Equipment	☐ Irritation	☐ Leg(s)/Ankle(s) – L/R	☐ Other
☐ Animal/Insect Bite	☐ Burn (Thermal/Chemical)	☐ Feet/Toes – L/R	
☐ Other ______________	☐ Other __________________	☐ Multiple	

Received By: ________________________ Date Received: _________________ Supplemental RMEH&S Investigation Report: ☐ Yes ☐ No

Office of Risk Management

SUMMARY OF INVESTIGATION

This section should be completed by Department Manager or Supervisor

Accident/Incident Investigation:

- Length of service with SMU? Years: _____ Months: _____
- Length of service in current position? Years: ______ Months: _____
- Identify employee's regular/normal job duties:____

____

- Was employee performing regular/normal job duties when the incident occurred? ☐Yes ☐No

If *no*, please explain:____

- Are there any written standard operating procedures or rules for performing the job tasks? ☐Yes ☐No
- Was the employee following the appropriate procedures or rules when the incident occurred? ☐Yes ☐No

If *no*, please explain:____

- Does the job tasks require and special safety requirements (PPE, permits, special tools, etc.)? ☐Yes ☐No

If *yes*, please explain:____

- Did any "**unsafe act**" on the employee's part directly contribute to this incident? ☐Yes ☐No

If *yes*, please explain:____

- Were any "**unsafe conditions**" present that contributed to the incident? ☐Yes ☐No

If *yes*, please explain:____

- Identify any additional factors that may have contributed to the incident: *lack of training, lack of supervision, faulty tools/equipment, etc.*

____

Corrective Action(s):

Identify what corrective actions have been or will be implemented to eliminate or minimize recurrence of this type of incident:

Corrective Action	**Projected Date**	**Responsibility**
1. ______________________	__________	__________
______________________	__________	__________
2. ______________________	__________	__________
______________________	__________	__________
3. ______________________	__________	__________
______________________	__________	__________
4. ______________________	__________	__________
______________________	__________	__________

Name Print: ______________________________ Title/Position:______________________

Signature:______________________________ Date:______________________

Phone/Ext:______________

Return completed form to Office of Risk Management, Box 231, within 48 hours of incident