UNIVERSITY OF MIAMI – INCIDENT REPORTING FORM

DO NOT COMPLETE THIS FORM IF YOU ARE AN EMPLOYEE REPORTING A WORK-RELATED INJURY/ILLNESS.

University of Miami Employees **Must** Report Work Injury/Illness in Workday.

Visit the Risk Management **Workers' Compensation** web page to view the revised Work Injury/Illness Reporting Instructions.

Please review our privacy statement (http://www.miami.edu/index.php/privacy_statement/) relating to gathering personal information before proceeding.

A. Biographical Information:

Last Name: _____ First Name: _____Middle Initial: ____

Home Address: (*including City, State,* Zip)_____

Home Phone: _____ Cell Phone: _____

Age: _____ Email Address:_____

B. Affiliation:

Category (Select One):

- ☐ Student
- ☐ Patient
- ☐ Visitor/Guest
- ☐ Wellness Center Member
- ☐ Wellness Center Camper
- ☐ Contractor
- ☐ Other

C. Incident General Information:

Date of Incident (mm/dd/yyyy): _____ Time (hh:mm): _____ AM☐ PM☐

Location of Incident (Include Building Name and location):_____

_____

Date Reported (mm/dd/yyyy): _____ Time Reported (hh:mm): _____ AM☐ PM☐

To Whom Reported: _____

REQUIRED *- First & Last Name*

Witness Name: _____ Contact Phone Number:_____

Witness Name: _____ Contact Phone Number: _____

D: Incident Details (describe what happened):

_____

_____

_____

E. Name of Person Completing this Form:

Print Name: _____ Email Address:_____

Relationship to injured person: _____ Contact Phone Number: _____

F. Submission and Reporting:

1. **After completing this form, press submit to complete this process.**
2. **If electronic submission fails, this form may be printed or emailed to riskmanagement@miami.edu or faxed to (305) 284-3405.**

Clear **Submit**