



UNIVERSITY OF SOUTH ALABAMA

Employment Location

☐ **USA Campus** (includes all facilities except USA Hospitals)

☐ **USA Medical Center**

☐ **USA Children's and Women's Hospital**

Report of Accident/Incident Involving:

[] Employee

[] Visitor

[] Student

Name: Last First Middle		Date of Birth:
Home Address:		Home Phone Number:
Social Security #:	Department (if employee):	Business Phone Number:
Name of Supervisor:	Office Address:	Business Phone Number:

DETAILS OF ACCIDENT/INCIDENT

Incident Date:	Date Reported to Supervisor	Time: _____ a.m. _____ p.m.	Location of Accident:
Description of What Happened:			
Report What You Think Contributed to the Accident:			
Type of Injury (cut, puncture, burn, etc.)		State Body Part Injured (left or right)	
Witness to Accident/Incident Name: Phone:		Signature of Supervisor (if employee), Hospital Administrator (if hospital visitor), University Police (if campus visitor): Date:	

Signature of Injured/Reporting Party: _____ **Date:** _____

By signing above, I, the injured/reporting party, understand that I have one year from the date of the accident/incident for filing a claim with the State Board of Adjustment and that any questions I have regarding the State Board should be directed to Human Resources (for employees) or the Office of Risk Management.

Was medical treatment received: ☐ Yes ☐ No

If yes, Date of treatment _____

Name and address of provider:

This document, when prepared and maintained by USA Hospitals, is done so in the QA activity of the University of South Alabama Hospitals, and is PRIVILEGED AND CONFIDENTIAL pursuant to §22-21-8 and §34-24-58 of the 1975 Code of Alabama

DO NOT DUPLICATE

Department Head/Supervisor Review/Actions:	
Recommendations:	
Date:	Signature

Administrative Review/Actions:	
Recommendations:	
Date:	Signature

Safety Officer Review/Actions: (if applicable)	
Recommendations:	
Date:	Signature

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University of South Alabama Human Resources
EMPLOYEE INCIDENT REPORT ROUTING FORM

Employee: _____

Date Submitted: _____

Supervisor: _____

Date Received: _____ Sent: _____

Department Head: _____

Date Received: _____ Sent: _____

Employee Health: _____
(Hospital Employees Only)

Date Received: _____ Sent: _____

Human Resources: _____

Date Received: _____ Sent: _____

Safety Officer: _____

Date Received: _____ Sent: _____

Administration: _____

Date Received: _____ Sent: _____

Risk Management: _____

Date Received: _____

Each department listed should forward the Incident Report to the department listed next on the form. If a department has signed off on the form, please forward to the next department as needed.