

## Visitor/Guest Incident Accident Investigation Form

\*\*Employee/Students/Medical Residents accidents/incidents should be reported using the Supervisor's First Report of Injury Form.

|  |  |   |
|--|--|---|
| Name of Claimant (s):                        | Contact Phone #:   | Claimant(s) address:                    |
| Date Occurred/Time Occurred:                 | Incident Building:   | Incident Location/Room:                 |
| Name of Person(s) Reporting Incident:        | Contact Phone #:   | Department (if an employee) or address: |
| Name of Witness(es):                         | Witness(es) Phone #:   | Witness(es) Department or Address:      |
| Date & Time Reported:                        | Send completed form to UT Safety, Health, Environmental and Risk Management, OCB 1.330, Fax # 713-500-8111, Voice # 713-500-8100. Visitors/Guests are defined as individuals who are not covered by UTHSC under any insurance including, but not limited to health insurance or workers' compensation. This form is for <b>RECORD ONLY</b> . |   |
| Detailed Description of the Incident:        |  |   |
| Detailed Description of Injuries or Damages: |  |   |
| Attachments                                  | Signature of Person Reporting:   |   |