Injury Report Form

Name of Injured _____ Male ____ Female ____

Permanent Address _____ City _____ State ____ Zip _____

Telephone Home ( ) _____ Work ( ) _____

Student Identification Number _____

Name (s) of Witness _____

Telephone Home ( ) _____ Work ( ) _____

Statement of Injured Person or Witness

A. (If injured person or witness is unavailable, information is to be completed by individual completing report.)

Date of Accident __/_____/_____/ Time _____ AM ____ PM ____

Location of Accident

_____

Summarize how injury, illness, or exposure occurred _____

_____

Kind of injury _____

Part of Body Affected (specific part of the body i.e., left wrist, right leg) _____

_____

Signature of Injured Person or Witness _____

_____

To be completed by First Aid Provider

B. Symptoms and complaints of the injured person _____

_____

Describe the nature and extent of injury you observed _____

_____

Treatment, recommendations, and referral

_____

_____

Signature of First Aid provider_____

_____

To be completed by Supervisor for Employee Injury/Illness
(Attach additional information if necessary)

C. Evaluation of how accident occurred/contributing factors_____

_____

Possible Preventative Actions (actions that have been/will be taken to prevent recurrence) _____

_____

For Human Resources Use Only

D. Lost Time: Yes _____ No _____ Number of Days _____
Anticipated Release Date _____ Work Restrictions _____

Medical Treatment _____

MUST BE COMPLETED AND RETURNED WITHIN 24 HOURS OF ACCIDENT