**REPORT OF INJURY OR ILLNESS**

**Injured Party Information**

**First Name:** Click to enter text. **Last Name:** Click to enter text. **MI:** Click to enter text.

**Status:** Student [ ]  Faculty/Staff [ ]  Visitor [ ]

**Address:** Street, City, State, ZIP – Add both Physical and Mailing if different

**Phone:** Enter Phone # **Alt. Phone:** Enter Phone # **Email:** Enter Email Address

**DOB**: Enter DOB (MM/DD/YYYY) **Age**: Enter Age

**Position OR Program of Study**: If Employee Injury - enter Position, If Student Injury - enter Program of Study, if Visitor - leave blank

**Injury/Exposure Information**

**Date:** Click to Select Date **Time:** Enter Time **Campus:** Alfond [ ]  Fairfield [ ]  Off-Campus [ ]

**Location of Injury/Exposure:** Describe in detail; Building, Room #, Hallway, Parking Lot, Walkway, etc.

**Describe events which precipitated the injury/exposure/illness:** Include all details, including contributing factors and how incident occurred (e.g. Student cut foot on broken glass from broken vial)

**Describe any objects/conditions that directly resulted in the injury/exposure/illness:** e.g. Icy walkway, slippery surface, moving vehicle, etc.

**Describe injury or illness and indicate the part of the body affected:** e.g. Sprain, break, cut, etc. to [Part of Body]

**What could prevent a recurrence of this or a similar Incident:** Enter any ideas/suggestions

**Treatment Information**

**Treatment:** None [ ]  First Aid [ ]  Outpatient [ ]  Ambulance [ ]  ER [ ]  Hospitalization [ ]  Other [ ]

**Treating Clinician & Contact Information:** Enter Name, Title, Phone Number

**Facility Name & Contact Information:** Enter for any utilized Office Clinic/Urgent Care/Hospital

**Degree of Injury/Illness**

**Non-disabling:** [ ]

**Temporary Incapacity:** [ ]  **Date:** Enter Date incapacity began

**Permanent Disability:** [ ]

**Death:** [ ]  **Date:** Enter Date of Death

**If Student** - **Has Student Returned to Program?** Yes: [ ]  No: [ ]  **Date:** Enter Return Date

**For Illness**

**Date of Last Exposure:** Enter Date **Date of Clinical Diagnosis:** Enter Date

**Witnesses**

**Person In Charge:** Enter the Faculty/Staff/Supervisor in charge When/Where accident occurred

**Name**: Enter Name **Student ID/Phone #**: Enter ID/Phone Number

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**Name**: Enter Name **Student ID/Phone #**: Enter ID/Phone Number

**Report Prepared By**

**Name:** Enter Reporting Individual’s Name **Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Role/Title:** Student/Staff/Faculty/etc. **Date Report Completed:** Enter Date

**Safety Committee Review**

**Name**: Enter Safety Committee Member who reviewed this form

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**Date:** Enter Date of Review

**Comments:** Enter Safety Committee Review Comments

**Employee Injury ONLY - Supervisor Information**

**Supervisor:** MUST be completed by Supervisor

**Date Reported:** Enter Date **By Whom:** Enter Date

**Did Incident result in lost time?** Yes: [ ]  No: [ ]  **Date:** If YES, enter Date

**Did Incident result in work restrictions?** Yes: [ ]  No: [ ]  **Date:** If YES, enter Date

**Has Employee returned to work?** Yes: [ ]  No: [ ]  **Date:** If YES, enter Date

**Has Injured Employee received**
**safety instruction/training related** Yes: [ ]  No: [ ]  **Date:** If YES, enter Date
**to incident?**

**What could prevent a recurrence of this or a similar Incident:** Enter any ideas/suggestions