

ACCIDENT/INCIDENT REPORT FORM

(Should be completed within 24 hours of the incident)

Date of incident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time: \_\_\_\_\_\_\_\_ AM/PM

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**[ ] Student** **[ ] Employee** **[ ]  Visitor [ ] Vendor/Other**

**Campus Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Accident Location** (be very specific):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Details of incident:**

**University Equipment involved**: **[ ]  Yes [ ]  No If YES: Did equipment appear to be used appropriately? [ ]  Yes [ ]  No**

 **Was there any malfunction of equipment? [ ]  Yes [ ]  No**

**Notes related to equipment:­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| --- | --- | --- | --- |
| **Body Part Injured:** |  **Head** |  **Trunk** |  **Extremities** |
| Left |  | Right | Left |  | Right | Left |  | Right | Left |  | Right |
| [ ]  | Ear | [ ]  | [ ]  | Abdomen | [ ]  | [ ]  | Ankle | [ ]  | [ ]  | Lower Arm | [ ]  |
| [ ]  | Eye | [ ]  | [ ]  | Back | [ ]  | [ ]  | Elbow | [ ]  | [ ]  | Lower Leg | [ ]  |
| [ ]  | Face | [ ]  | [ ]  | Chest | [ ]  | [ ]  | Finger | [ ]  | [ ]  | Thumb | [ ]  |
| [ ]  | Head | [ ]  | [ ]  | Groin | [ ]  | [ ]  | Foot | [ ]  | [ ]  | Toes | [ ]  |
| [ ]  | Neck | [ ]  | [ ]  | Shoulder | [ ]  | [ ]  | Hand | [ ]  | [ ]  | Upper Arm | [ ]  |
| [ ]  | Scalp | [ ]  | [ ]  | Trunk | [ ]  | [ ]  | Hip | [ ]  | [ ]  | Upper Leg | [ ]  |
|  |  | **[ ]**  | Knee | **[ ]**  | **[ ]**  | Wrist | **[ ]**  |
|  |  |  |  |  |  |  |  |  |
| **Type of Injury** **Suspected:** | [ ]  Laceration | [ ]  Bruise  | [ ]  Dislocation |
| [ ]  Sprain/ Strain | [ ]  Fracture | [ ]  Concussion |
| [ ]  Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |
| **Treatment Given:** | [ ]  Ice | [ ] Applied Bandage/Dressing | [ ]  Kept immobile |
| [ ] Stopped Bleeding | [ ]  Washed Wound | [ ]  Observed only |
| [ ] Other: ­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  No treatment was required or desired by  |  |
|  |  |  |  |
| **Further Care:** | [ ]  Parent/Emergency Contact took home | [ ]  Parent/Emergency Contact took Emergency Room |
| [ ]  Parent/Emergency Contact took to doctor | [ ]  Transported from school by ambulance |
| [ ]  Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Witnesses: *(attach statements)*** |  |
| **Name of Person Reporting Injury:** |  |
|  |  |  |
| ***Signature of injured person*** |  | ***Date*** |

|  |  |
| --- | --- |
| *SWU logo* |  |

***WITNESS STATEMENT FORM***

 ***Witness Information***

|  |  |  |  |
| --- | --- | --- | --- |
| ***Name:*** |  | ***Birth Date:*** |  |
| ***Address:*** |  | ***Phone #:*** |  |
| ***Home Phone #:*** |  | ***Cell Phone #:*** |  | ***Work Phone #:*** |  |
|  |  |

***Accident/Incident Information***

|  |  |
| --- | --- |
| ***Name of Student/Employee/Visitor:*** |  |
| ***Date/Time:*** |  | ***Location:*** |  |
| ***Please describe the details of the accident/incident:*** |
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|  |  |  |
| *Signature of Witness* |  | *Date* |