



INCIDENT-ACCIDENT REPORT

Date of Injury ___/___/___ Date Reported ___/___/___ Time of Injury ___:___ a.m. / p.m.

I.D. # _____ Employee Student Other _____ Sex: Male Female

Campus/Dept. _____ Occupation _____

Name _____ S.S.# _____ - _____ - _____

Address _____ Age _____ D.O.B. _____

Home Phone No _____ Does Employee speak English? Yes

Single Married Divorce Widow Separated

Race: White Black Hispanic Asian Native American Other _____

Next of Kin _____ Address _____ Phone _____

Location of Accident/Incident _____

List of Witnesses _____ Doctor's Name _____

Nature of Accident/Incident			Part of Body Injured			
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Eye Injury	<input type="checkbox"/> Abdomen	<input type="checkbox"/> Eye	<input type="checkbox"/> Knee	<input type="checkbox"/> Ankle
<input type="checkbox"/> Burn	<input type="checkbox"/> Bruise/Bump	<input type="checkbox"/> Fracture	<input type="checkbox"/> Face	<input type="checkbox"/> Leg	<input type="checkbox"/> Arm	<input type="checkbox"/> Finger
<input type="checkbox"/> Cut	<input type="checkbox"/> Slip/Fall	<input type="checkbox"/> Laceration	<input type="checkbox"/> Teeth	<input type="checkbox"/> Chest	<input type="checkbox"/> Back	<input type="checkbox"/> Foot
<input type="checkbox"/> Puncture	<input type="checkbox"/> Convulsion	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Wrist	<input type="checkbox"/> Hand	<input type="checkbox"/> Elbow	<input type="checkbox"/> Head
<input type="checkbox"/> Shock	<input type="checkbox"/> Sprain		<input type="checkbox"/> Other _____			
Other _____					Left	right
						both

How and why injury/illness occurred? _____

Were the parents notified? Yes No Time notified ___:___ a.m. / p.m.

Person notified: _____ Relationship: _____

Treatment and Disposition _____

Ambulance called: Time _____ Unit _____ Name of Hospital _____

Person Released to: _____ Relationship: _____

Signature _____

Nurse

Principal / Director

