



# 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