Appendix A. Injury Report

Injury Report

To be completed by injured person

Today's Date:

Name: Soc. Sec #:

Circle: Employee, student, visitor, student employee

Address: Phone:

Date of Accident: Time: Location:

Type of injury:

Part of body injured:

Date reported: Time: Reported to:

Description of accident:

Contributing unsafe conditions of actions:

Tools, chemicals, or equipment involved:

Suggestions for correcting conditions:

Witness (name, address, and phone number):

Treatment: First aid, Sent home, Emergency room

Sent to physician (name):

Admitted to hospital (name):

Medical attention received:

Related previous injuries:

Signature: Date:

Students and Visitors
Complete Front side only and return to
Campus Public Safety Office, University Services Building

Employees and Student Employees

Return to Human Resources Office

To be completed by SU employees only:
Work phone #:
Department: Position:
Full time, Part time, Temporary Student
Could this accident have aggravated a pre-existing injury or illness? Yes No
If yes, explain:

To be completed by employee's supervisor:
(Please complete as soon after the accident as possible. Report lost time to date if necessary.)
Work time lost: Date(s) of lost time:
Date returned to work: Light duty days:

Describe how and why accident occurred:

Was the accident area inspected? yes no Comments:

List actions taken to prevent similar accidents in the future (include target date, completion date, and name of person responsible):
1)
2)
3)

Comments:

Supervisor name (print)

Supervisor signature: Date:

Copies will be sent to: Environmental Health and Safety Coordinator, and Campus Public Safety

Reviewed May 2011