

Accident/Incident Report form

(Complete this form with the information available. DON'T HOLD THE FORM TO OBTAIN ADDITIONAL INFORMATION)

Name of person completing this incident report: _____

Phone number of person completing this incident report: _____

Name of injured person: _____

Date of Incident: _____ AM / PM Time of incident: _____ AM / PM

Time the employee began work on the date of the incident: _____ AM / PM

Date the employer was notified of the incident: _____ Last day of work after the injury: _____

Employee's occupation (job title) when injured: _____

Employee's assigned department: _____

Did the injury occur on the employer's premises? Yes / No

If no, provide the address of the injury occurred: _____

Type of injury/illness:

Body part affected:

Extent of Injury:

Puncture	Bruise/Contusion	Laceration	Fracture
Irritation	Heat/Cold Stress	Infection	Dislocation
Hernia	Insect/Animal Bite	Amputation	Respiratory
Abrasion	Chemical Exposure	Muscle Strain	Muscle Sprain
Burn	Other		

Provide details of the injury: (What happened? Tell us how the injury occurred.)

What object or substance directly harmed the employee? (Examples: concrete floor; chlorine; radial arm saw)

Where was the employee treated? _____

Was the employee treated in an emergency room? Yes / No

Provide the information of the physician or other health care professional:

Name: _____ Address: _____ Phone: _____

Was the employee hospitalized overnight as an in-patient? Yes / No

If hospitalized, provide the hospital information:

Name: _____ Address: _____ Phone: _____

If another person, not employed by Prescott College caused the accident, provide the name, address, phone and email address of that person: _____

Witness (Provide name/phone numbers of any witnesses to the injury): _____

If the validity of the claim is doubted, state the reason: _____

If no medical attention was desired and/or required obtain signature from injured party...

Signature of injured party

Date

(By signing above the injured party acknowledges that he/she did not desire and/or require medical attention.)

* Return this form to human resources immediately after injury *