

ST. AMBROSE UNIVERSITY

**INCIDENT REPORT
(Information on ALL Accidents)**

Student Employee Visitor

Sex: M F

Date of Birth _____

Social Security Number _____

Name _____ Home Phone: _____

Home Address _____ Business Phone: _____

Time Accident Occurred: Hour _____ A.M. _____ P.M./Date _____

Time Employee Began Work: _____ A.M. _____ P.M.

Location of Accident: University Building University Grounds Other (specify) _____

TYPE OF INJURY

<input type="checkbox"/> Abrasion	<input type="checkbox"/> Altercation	<input type="checkbox"/> Animal Bite	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Laceration	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Adverse medication reaction	<input type="checkbox"/> Amputation	<input type="checkbox"/> Human Bite	<input type="checkbox"/> Fracture	<input type="checkbox"/> Poisoning	_____
<input type="checkbox"/> Aspiration	<input type="checkbox"/> Burns	<input type="checkbox"/> Fall	<input type="checkbox"/> Puncture	_____	_____
<input type="checkbox"/> Bite	<input type="checkbox"/> Bruise	<input type="checkbox"/> Bee Sting	<input type="checkbox"/> Seizure	_____	_____

PART OF BODY INJURED

<input type="checkbox"/> Abdomen	<input type="checkbox"/> Chest	<input type="checkbox"/> Face	<input type="checkbox"/> Hand	<input type="checkbox"/> Mouth	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Tooth	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Ankle	<input type="checkbox"/> Ear	<input type="checkbox"/> Finger	<input type="checkbox"/> Head	<input type="checkbox"/> Neck	<input type="checkbox"/> Thigh	<input type="checkbox"/> Wrist	_____
<input type="checkbox"/> Arm	<input type="checkbox"/> Elbow	<input type="checkbox"/> Foot	<input type="checkbox"/> Knee	<input type="checkbox"/> Nose	<input type="checkbox"/> Thumb	_____	_____
<input type="checkbox"/> Back	<input type="checkbox"/> Eye	<input type="checkbox"/> Groin	<input type="checkbox"/> Leg	<input type="checkbox"/> Scalp	<input type="checkbox"/> Toe	_____	_____

COURSE OF ACTION

First-aid treatment By: (Name) _____

Sent to Student Health Services By: (Name) _____

Sent Home Residence Hall By: (Name) _____

Sent to Emergency Room By: (Name) _____

Sent to hospital Physician's name: _____

By: (Name) _____

Name of Hospital: _____

Sent to The Davenport Clinic By: (Name) _____

Physician's name: _____

Was a parent or other individual notified? No Yes Date: _____

Name of individual notified: _____

By Whom? (enter name) _____

Witnesses: 1. Name: _____ Address: _____

Witnesses: 2. Name: _____ Address: _____

DESCRIPTION OF ACCIDENT:

1. How did accident happen? _____

2. What was individual doing just before the incident occurred? _____

3. Where was individual? _____

4. Specify any tool, machine or equipment involved. _____

5. What was the injury or illness? _____

6. What object or substance directly harmed the employee? _____

Signed: (University Official) _____ **Date:** _____

ADMINISTRATIVE DEPARTMENT

1. Corrective action taken as a result of the accident. _____

2. Full or part-time employee: _____

3. Tax filing status: Single Married/Joint Single/Head of household Married/File Separate

4. Marital status: Unmarried Married Separated

5. Employee number of dependents: _____

6. Indicate if accident (activity) was part of normal job duties: _____

7. Any restricted days: _____

8. Any lost work days: _____

9. Date hired: _____

Send completed form to the office of Health Services. A zerox copy will be forwarded to the Business Office.

Revised Date: _____

OSHA CASE # _____