

# ACCIDENTAL INJURY AND ILLNESS REPORT

Please complete and send to Environmental Health and Safety Office

<b>NAME:</b> (Last, First, MI) <input type="text"/>	<b>ADDRESS:</b> (Number, Street, City, State, ZIP) <input type="text"/>
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<b>Social Security or Student #</b> <input type="text"/>	<b>Telephone Number</b> <input type="text"/>	<b>Age</b> <input type="text"/>	<b>Sex</b> <input type="checkbox"/> Female <input type="checkbox"/> Male	<b>Classification:</b> (check one only) <input type="checkbox"/> Student <input type="checkbox"/> Visitor <input type="checkbox"/> Other: _____
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<b>Date and Time of Occurrence:</b> Date: _____ Time: _____	<b>Accident Location:</b> Site of Occurrence (Bldg. Name, Room No., stairs, hallway, etc.) If outside bldg, give location in reference to nearest bldg, eg. on walkway mauka of K Hall
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<b>Instructor:</b> (If applicable) <input type="text"/>	<b>Department:</b> <input type="text"/>	<b>Witness</b> (Name and Phone Number) <input type="text"/>
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**Accident Description:** (Describe fully, stating whether injured or exposed person was struck, fell, etc. and all factors contributing to accident or illness. Include activity at time of accident and object or substance which directly injured the person. Use additional sheets if necessary)

**Nature of Injury or Illness:** (Describe in detail, the nature of the injury or occupational illness and the part of the body affected)

<b>Emergency Care and Patient Status</b> <input type="checkbox"/> First aid only, not at Hospital or by Physician <input type="checkbox"/> Referred to Hospital or Medical Personnel, current status unknown <input type="checkbox"/> Treatment at Hospital or by medical personnel <input type="checkbox"/> Other, specify: _____	<b>Treated By:</b> (Name and address of Physician or Hospital, if known) <input type="text"/>
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**This Report Prepared By:**

Print Name \_\_\_\_\_ Phone No. \_\_\_\_\_ Date \_\_\_\_\_

**FOR EHSO USE ONLY**

Investigation Conducted:  Yes  No Date: \_\_\_\_\_ Time: \_\_\_\_\_

Comments:

Person Conducting Investigation: \_\_\_\_\_