**Commonwealth University of Pennsylvania**

**Accident/Incident/Injury Report**

Campus: [ ]  Bloomsburg [ ]  Clearfield [ ]  Lock Haven [ ]  Mansfield

Date of Report:

Is the person completing this form a: Student Visitor Other:

*Please Print or Type Responses*

Date of Accident/Incident/Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time of Accident/Incident/Injury: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Campus Representative Reported to and Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person Injured and/or Involved in the Accident/Incident:

 (Last): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (First): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: Telephone Number:

Street Address:

City:

County:

State:

Zip:

 Were you injured on campus premises? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where did the incident occur? (specific location):

Describe how the accident/incident occurred (be specific and use additional paper if needed):



How would you prevent this accident/incident from recurring?

Did anyone witness the accident/incident? Yes No

If yes, give names:

Did you sustain an injury? Yes No

If yes, what body part was affected?

Left Side Right Side N/A Please describe the injury:

Initial treatment:

No Medical Treatment Minor Treatment by Employee Clinic/Hospital

Panel Physician Employee Physician Emergency Care Hospitalization for More Than 24 Hours

Student Health Services

Did you sustain damage to personal property? Yes No

If yes, describe:

**Signature: Date:**

 **Please Submit to:** Office of Workplace Safety

 Bloomsburg Campus: BMC-2

 Lock Haven Campus: Facilities Building

 Mansfield Campus: 108 Brooks Maintenance