

REPORT OF INCIDENT OR ACCIDENT

(Non-University employee)

CALIFORNIA STATE UNIVERSITY, Fresno

ATTENTION: This form contains information relating to an injured individual's health and must be used in a manner that protects the confidentiality of the injured to the extent possible while the information is being used for safety and health purposes. This form must be completed within 24 hours of receiving information of an occupational or other university-related injury or illness and forwarded to Environmental Health & Safety/Risk Management MS/PO 140 or faxed to 278-1153.

IMPORTANT: Please go to www.csufresno.edu/ehsrms/forms Report an Incident or Accident (non-University employee), to ensure that you are using the most current version of this form.

SECTION 1: UNIVERSITY RELATIONSHIP (SELECT ONLY ONE)

Student Volunteer Visitor Contractor

Police Report Made YES NO

SECTION 2: INCIDENT TYPE (SELECT ONLY ONE)

Injury Illness Other (Vehicle, Near Miss, Dangerous Condition, Exposure Incident) _____

SECTION 3: INVOLVED/INJURED'S INFORMATION

First Name: _____ Last Name: _____ M.I.: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Work Ph: _____

Male Female Date of Birth: _____ Driver's License Number: _____

SECTION 4: INCIDENT DETAILS

Date of Injury/Illness: _____ Time: AM/PM _____ Location: _____

DESCRIBE THE INCIDENT (STATE ONLY THE FACTS). Attach additional sheet of paper if necessary.

What was the person doing just prior to and at the time of the incident? What objects/conditions contributed to the incident?

Name(s) of Injured Persons & Witnesses:

| | | |
|-----------------------------|---|----------------------------------|
| 1. NAME (Last, First, M.I.) | WORK ADDRESS (Street, City, State, Zip) | WORK TELEPHONE (Area Code + No.) |
| DRIVER'S LICENSE NUMBER | HOME ADDRESS (Street, City, State, Zip) | HOME TELEPHONE (Area Code + No.) |
| 2. NAME (Last, First, M.I.) | WORK ADDRESS (Street, City, State, Zip) | WORK TELEPHONE (Area Code + No.) |
| DRIVER'S LICENSE NUMBER | HOME ADDRESS (Street, City, State, Zip) | HOME TELEPHONE (Area Code + No.) |
| 3. NAME (Last, First, M.I.) | WORK ADDRESS (Street, City, State, Zip) | WORK TELEPHONE (Area Code + No.) |
| DRIVER'S LICENSE NUMBER | HOME ADDRESS (Street, City, State, Zip) | HOME TELEPHONE (Area Code + No.) |

If the incident resulted in an injury or illness, answer the following questions.

- a) Did the individual receive medical treatment in an emergency room? YES NO
- b) Was the individual hospitalized overnight as an in-patient? YES NO
- c) Did the individual receive medical treatment beyond basic first aid? YES NO
- d) Did the injury or illness result in death? YES NO

SECTION 5: HOSPITAL/CLINIC INFORMATION

Name of Facility: _____

Address of Facility: _____

Treating Physician: _____ Phone Number: _____