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, emailed to lisak@csufresno.edu 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 PERSON'S INFORMATION

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

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

Home Ph: _____ Work Ph: _____

☐ Male ☐ Female Date of Birth: _____

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 Witnesses:

1. NAME *(Last, First, M.I.)*	ADDRESS *(Street, City, State, Zip)*	CONTACT TELEPHONE *(Area Code + No.)*
2. NAME *(Last, First, M.I.)*	ADDRESS *(Street, City, State, Zip)*	CONTACT TELEPHONE *(Area Code + No.)*
3. NAME *(Last, First, M.I.)*	ADDRESS *(Street, City, State, Zip)*	CONTACT 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: _____

SECTION 6: REPORTING INDIVIDUAL

Reporting Employee's Name*(Print or Type)* _____ Telephone *(Area Code + No.)* _____

Reporting Employee's Department/Office _____ Date _____