Accident/Incident Report form

(Complete this form with the information available. DON’T HOLD THE FORM TO OBTAIN ADDITIONAL INFORMATION)

Name of person completing this incident report: __________________________
Phone number of person completing this incident report: __________________________

Name of injured person: ____________________________________________________
Date of Incident: ________________ Time of incident: ________________ AM / PM
Time the employee began work on the date of the incident: ________________ AM / PM
Date the employer was notified of the incident: ________________ Last day of work after the injury: ________________
Employee’s occupation (job title) when injured: __________________________
Employee’s assigned department: __________________________
Did the injury occur on the employer’s premises? Yes / No
If no, provide the address of the injury occurred: __________________________
Type of injury/illness: __________________________________________

<table>
<thead>
<tr>
<th>Body part affected:</th>
<th>Extent of Injury:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Puncture</td>
<td>Fracture</td>
</tr>
<tr>
<td>Bruise/Contusion</td>
<td>Dislocation</td>
</tr>
<tr>
<td>Irritation</td>
<td>Infection</td>
</tr>
<tr>
<td>Hernia</td>
<td>Amputation</td>
</tr>
<tr>
<td>Abrasion</td>
<td>Muscle Sprain</td>
</tr>
<tr>
<td>Burn</td>
<td>Muscle Strain</td>
</tr>
</tbody>
</table>

Provide details of the injury: *(What happened? Tell us how the injury occurred.)*

What object or substance directly harmed the employee? *(Examples: concrete floor; chlorine; radial arm saw)*

Where was the employee treated? __________________________
Was the employee treated in an emergency room? Yes / No
Provide the information of the physician or other health care professional:
Name: __________________________ Address: __________________________ Phone: __________________________
Was the employee hospitalized overnight as an in-patient? Yes / No
If hospitalized, provide the hospital information:
Name: __________________________ Address: __________________________ Phone: __________________________
If another person, not employed by Prescott College caused the accident, provide the name, address, phone and email address of that person: __________________________
Witness (Provide name/phone numbers of any witnesses to the injury):

If the validity of the claim is doubted, state the reason:

* If no medical attention was desired and/or required obtain signature from injured party... *

Signature of injured party __________________________
Date __________________________

(By signing above the injured party acknowledges that he/she did not desire and/or require medical attention.)

* Return this form to human resources immediately after injury *