Accident/Incident Report Form
(For Use by ESU Employees, Students, and Visitors)

Instructions for Report Completion: East Stroudsburg University employees, students, and visitors are to complete this accident/incident form as soon as possible, preferably within twenty-four (24) hours of the accident/incident. The completed form must be sent to the Office of Human Resources, East Stroudsburg University, 200 Prospect Street, East Stroudsburg, PA 18301. Please print all information.

Email:	askhr@esu.edu
Phone:	570-422-3422
FAX:	570-422-3450

IMPORTANT: All ESU employees and student employees must complete and sign the form, and obtain their supervisor's signature.

INDIVIDUAL IDENTIFICATION

1. Date/Time of accident/incident: _____
2. Full Name: _____
3. Street Address: _____
4. City/State/Zip Code: _____
5. Home Phone Number: _____
6. Cell Phone Number: _____
7. Work Phone Number: _____
8. Email Address: _____
9. Date of Birth: _____
10. Gender: ☐ Male ☐ Female ☐ Not Specified
11. Job Title: _____
12. Department: _____
13. Date of Hire: _____
14. Employment Status: ☐ Full-time ☐ Part-time ☐ Student Worker ☐ Visitor
15. Employee Schedule: _____
16. Personnel Number: _____

ACCIDENT/INCIDENT INFORMATION

17. Location of accident/incident (Indoors- provide building, room number or area, such as stairs, hallway, etc. Outdoors- describe area): _____
    _____
    _____

Revised: 7/17/2026

18. County of accident/incident: _____

19. Were you performing regular job duties at the time of accident/incident?

☐ Yes ☐ No ☐ Not Applicable

20. Please describe details of the accident/incident (list equipment, materials, or chemicals if in use when accident/incident occurred): _____

_____

_____

_____

_____

_____

_____

21. Did injury occur?

☐ Yes ☐ No ☐ Not Applicable

22. If injury occurred, please indicate location: ☐ **Left** ☐ **Right**

☐ Hand	☐ Finger	☐ Arm	☐ Elbow	☐ Wrist
☐ Shoulder	☐ Neck	☐ Face	☐ Teeth	☐ Eye
☐ Foot	☐ Toe	☐ Leg	☐ Knee	☐ Ankle
☐ Head	☐ Ear	☐ Nose	☐ Throat	☐ Lungs
☐ Abdomen	☐ Groin	☐ Lower Back	☐ Mid Back	☐ Upper Back

23. Describe the injury in detail (Cut, sprain, burn, exposure, etc.): _____

_____

_____

24. Did the accident/incident involve a slip, trip, or fall?

☐ Yes ☐ No ☐ Not Applicable

25. Did the accident/incident involve lifting?

☐ Yes ☐ No ☐ Not Applicable

26. Is this type of work performed regularly?

☐ Yes ☐ No ☐ Not Applicable

27. If injury occurred, did it appear immediately?

☐ Yes ☐ No ☐ Not Applicable

28. If injury occurred, did it aggravate a previous injury?

☐ Yes ☐ No ☐ Not Applicable

29. Were safeguards or safety equipment available?

☐ Yes ☐ No ☐ Not Applicable

30. Were safeguards or safety equipment used?

☐ Yes ☐ No ☐ Not Applicable

31. Were there any witnesses?

☐ Yes ☐ No ☐ Not Applicable

If yes, please list name and contact information for any witnesses:

Witness 1: _____

Witness 2: _____

Witness 3: _____

32. Did property damage occur?

☐ Yes ☐ No ☐ Not Applicable

33. If property damage occurred, please describe as best as possible: _____
_____
_____
_____

INFORMATION REGARDING MEDICAL TREATMENT/MISSED WORK TIME

34. Were you evaluated and/or treated by a medical provider/physician?
☐ Yes ☐ No ☐ Not Applicable
If yes, please provide medical provider/physician name and phone number below:
Medical Provider/Physician: _____
_____
Date(s) of treatment: _____
35. Did you go to a hospital?
☐ Yes ☐ No ☐ Not Applicable
If yes, please provide hospital name and date: _____
_____
36. Did you miss work?
☐ Yes ☐ No ☐ Not Applicable
If yes, workdays/times missed: _____
Last day worked: _____
Return to work date: _____
37. If you received medical treatment, do you have medical documentation? If so, please provide a copy to the Office of Human Resources.
☐ Yes ☐ No ☐ Not Applicable

SIGNATURE/AUTHORIZATION

I certify that the information set forth is true and correct to the best of my knowledge. By signing this form as an employee, I authorize any person(s) who hereafter provided medical attention, examination or treatment, or who may possess information or knowledge which may be used to render a decision in my claim for injury/disease of _____ (date), to disclose such information or knowledge to my employer and/or to any other agency contracted with by my employer to investigate this health claim. By signing this form as a non- employee, I authorize any person(s) who hereafter provided medical attention, examination or treatment, to disclose such information to East Stroudsburg University upon written request.

Name (please print): _____ Date: _____
Signature: _____

SUPERVISOR ONLY

Employee's Department: _____
Supervisor Name: _____
Campus Extension: _____

Supervisor Instructions: Please review circumstances of accident/injury with employee and include any actions if applicable that have been or will be taken to prevent future occurrence: _____

_____

_____

Supervisor Name (please print): _____ Date: _____

Supervisor Signature: _____

ESU HR ONLY

Date accident/incident/injury review performed: _____

Accident/incident/injury reviewed by: _____

Injury obtained in the normal course of the employee's job duties?

☐ Yes ☐ No ☐ Not Applicable

Medical documentation sent to Inservco:

☐ Yes ☐ No ☐ Not Applicable

Employee Workers' Compensation folder created:

☐ Yes ☐ No

Scanned and filed into HR internal folder:

☐ Yes ☐ No

WORKERS' COMPENSATION CLAIM INFORMATION

Workers' Compensation Claim filed on: _____

Claim Number: _____

Claim filed by: _____

Signature: _____