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, preferable within twenty-four (24) hours of the accident/incident and send to the Director of Environmental Health and Safety, East Stroudsburg University, 200 Prospect Street, East Stroudsburg, PA 18301. Phone: 570-422-3235  FAX 570-422-3677. PLEASE PRINT ALL INFORMATION.

IMPORTANT: All ESU Employees must sign the form and also obtain their supervisor’s signature on this report form.

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. Job Title____________________________________________________
11. Male  Female (Circle One)
12. Employment Status______________________________________________
13. Personnel Number______________________________________________
ACCIDENT/INCIDENT INFORMATION

14. Location of Accident/Incident (Indoors provide building, room number or area, such as stairs, hallway, etc... Outdoors describe area: ______________ 
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

15. County of Accident: __________

16. Were you performing regular job duties at the time of the accident/incident? □ Yes □ No □ Not Applicable

17. Did injury occur? □ Yes □ No

18. Did property loss or damage occur? □ Yes □ No

19. Please describe details of the accident/incident: List Equipment, Materials, or Chemicals if in Use When Accident Occurred: ____________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

20. If property damage occurred, please describe as best as possible:
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

21. Were there any witnesses? □ Yes □ No
Name and phone number of any witnesses (if 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 □ Lwr Back □ MidBack □ Upper Back

23. Describe injury (Cut, sprain, burn, exposure, etc...): ________________


24. Did the accident involve a slip, trip or fall? □ Yes □ No

25. Did the accident involve lifting? □ Yes □ No

26. Is this type of work performed regularly? □ Yes □ No

27. If injury occurred, did it appear immediately? □ Yes □ No

28. Were Safeguards or safety equipment available? □ Yes □ No

29. Were Safeguards or safety equipment used? □ Yes □ No

INFORMATION REGARDING MEDICAL TREATMENT/MISSED WORK TIME

30. Were you evaluated/treated by a medical provider/physician?
If yes, physician’s name and phone number_________________

Date(s) of treatment______________________________________

31. Did you go to a hospital? □ Yes □ No
   If yes, Date & Hospital name____________________________

32. Did you miss work? □ Yes □ No
   If yes, work days/time missed__________________________
   Last day worked____________________________________
   Return to work date__________________________________

33. If injury occurred, did it aggravate a previous injury?
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 ___________________________ Date__________________
(Print)
Signature___________________________________________________

ESU Employees 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/will be taken to prevent future occurrence:

Supervisor’s Signature_________________________________________

____________________________________________________________________

EHS Use Only

Accident/Injury Review Performed ________________

                     Date

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

    □ Yes          □ No          □ Not Applicable

Accident/Injury Reviewed by________________________________________

                     EHS personnel

Workers’ Compensation Claim

Worker’s Compensation Claim Filed on ________________ (Date)

Claim #____________________

Claim filed by____________________________________

                     EHS personnel

Revised November 18, 2015