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 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 February 1, 2018