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?

☐ Yes ☐ No

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 _____(Print) Date: _____

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