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  □ 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