UNIVERSITY OF EVANSVILLE ACCIDENT REPORT

To be prepared immediately after an accident by a student/employee or by the Supervisor upon notification of accident. One copy to be immediately forwarded to Risk Management Department.

INJURED GENERAL INFORMATION			
Name		Gender ☐ M☐ F	Date of Birth
Home Address	City	State	Zip
Home Phone #	Cell #	Soc Security #	
Classification: Married☐ Single ☐	Student☐ Faculty ☐	Staff ☐	Administration ☐

STUDENT SECTION (to be completed by injured party if currently attending classes at UE or enrolled at UE)

School Address	School Phone #
School Email Address	
Does student have Student Accident Insurance? Yes ☐ No ☐	

EMPLOYEE SECTION (to be completed by injured party if a UE student worker or part-time or full-time employee performing a job/work for the University)

Occupation when injured		Department	
Work Address	Work phone	Email	
Was this his/her regular occupation? Yes ☐ No ☐			
Place of regular employment	Dept.	Bldg	Room
Supervisor's Name		Supervisor's Phone #	
How long employed:	Years	Months	Full-time ☐ Part-time ☐
Number of hours worked per day		Number of days worked per week	

INFORMATION ABOUT THE ACCIDENT

Date of Injury	Time of injury am pm		
Place where accident occurred	Bldg	Room	Outdoor location
When was supervisor/instructor notified of injury?			

Part of Body Injured:

☐ eyes ☐ finger(s)

☐ face ☐ back

☐ head ☐ leg

☐ neck ☐ foot/feet

☐ chest ☐ toe(s)

☐ thigh ☐ shoulder(s)

☐ arm(s) ☐ wrist

☐ hand(s) ☐ abdomen

Type of Injury/Illness:

☐ fainting ☐ headache

☐ burn ☐ puncture

☐ cut ☐ poisoning

☐ fracture ☐ splinter

☐ sprain ☐ allergic reaction

☐ strain ☐ chemical contact/skin

☐ bruise ☐ chemical contact/eye

☐ concussion ☐ other:

Blood borne Pathogen Exposure

Yes	No	
☐	☐	Other than the injured person, was anyone else exposed to blood/body fluids?
☐	☐	If so, was that person wearing gloves?
☐	☐	Was there bare skin contact for anyone exposed?

Name of exposed person (s):

CAUSE OF INJURY

Yes ☐ No ☐ Did an unsafe act or condition contribute to the injury? If yes, explain:
Machine, tool or thing causing injury:
Kind of power (hand, foot, electric, steam, etc.)
Part of machine on which accident occurred
Was safety guard or regulation provided? Yes ☐ No ☐ Was it in use? Yes ☐ No ☐
Was injury caused by injured's failure to use or observe safety appliance or regulation? Yes ☐ No ☐ If yes, explain:
Describe fully how accident occurred and state what individual was doing when injured:
Witness Address Phone
EMPLOYEE ONLY
If employee, does injury prohibit working? Yes ☐ No ☐ Time lost due to accident/injury? Yes ☐ No ☐ If yes, probable length of disability?

TREATMENT OF INJURY

Yes	No	
☐	☐	Did injury require any first aid on location (e.g., treatment for cut, etc)?
☐	☐	Was the injured person sent to the campus health center?
☐	☐	If so, was additional treatment provided (e.g. medications)?
☐	☐	Was the injured person sent to an off campus medical facility for treatment?
☐	☐	If so, was the injured person treated in an emergency room?
☐	☐	Was the injured person hospitalized overnight (e.g. in-patient)?
☐	☐	Were x-rays or other tests taken?

Additional comments:

INFORMATION ABOUT PHYSICIAN/MEDICAL PERSONNEL

Campus Health Center	**Off Campus Medical Facility**
Name of person escorting injured person to Health Center	Transported by Ambulance ☐ Supervisor ☐ Self ☐ Other ☐
Name of nurse	Name of physician
Name of doctor	Treatment facility
Phone number	Street address
	City State Zip
	Phone number:

Report prepared by	Date

I verify that the above information is true: ____

Signature