UNIVERSITY OF RIO GRANDE AND RIO GRANDE COMMUNITY COLLEGE

Incident Report
Record of Injuries & Accidents

• *Must be filed within 24 hours of incident* •

Injured Person

NAME (Last, First, Middle Initial) _____ Social Security Number _____
HOME ADDRESS _____ Telephone _____
SCHOOL ADDRESS _____ Telephone _____
DOB _____ GENDER: ☐ Male ☐ Female CLASSIFICATION: ☐ Student ☐ Employee ☐ Visitor

The Accident or Exposure to Occupational Illness

Give location in which accident occurred or if it occurred outside university grounds at an identifiable address, give that address. If it occurred on a public highway or at any other place which cannot be identified by number & street, provide exact physical location of accident or exposure.

Place of accident or exposure (No. and street, city or town, state and zip code) _____

_____

Was place of accident or exposure on University grounds? ☐ Yes ☐ No

How did the accident occur? (Be specific and describe fully the events which resulted in the injury or exposure. Tell what the person was doing and how it happened. Name any equipment or substances involved and tell how they were involved. Give full details on all factors which led or contributed to the accident. *(Use separate sheet for additional space.)* _____

_____

_____

Injury or Illness

Describe the injury or illness in detail and indicate the part(s)of the body affected. (e.g., left shoulder, forehead, etc.) _____

_____

Name the object or substance which directly injured the person? (For example, the machine or thing he struck against or which struck him; the vapor or poison he inhaled or swallowed; the chemical or radiation which irritated his skin; or in cases of strains, hernias, etc., the thing he was lifting, pulling, etc.) _____

_____

Date & Time of Injury _____ Date Reported & To Whom _____

Name(s) & Phone Number(s) of any Witnesses _____

_____

Other (To be completed by Supervisor or Human Resources)

Name and Address of Physician _____

_____

☐ Treated in health services ☐ Transported per EMS ☐ Non-treated or non-transported
☐ Treated at Medical Facility ☐ Refused Treatment
Was first aid required? ☐ Yes ☐ No Was hospital/doctor treatment required? ☐ Yes ☐ No
If yes, give name and address of physician and/or hospital: _____

_____

Will injury cause loss of time? ☐ Yes ☐ No For How Long? _____

When is employee/student expected to return to work/school? _____

Action to prevent similar accidents (indicate if taken or recommended) ☐ CC-Health Services ☐ Human Resources ☐ Campus Police

_____

_____

CC-Person Completing Form _____
Date of Report _____ Prepared By _____ Official Position _____