

CS-13
C2128-681

STATE UNIVERSITY OF NEW YORK
REPORT OF ACCIDENT OR INJURY
(OTHER THAN A MOTOR VEHICLE ACCIDENT)

To be completed by Safety Supervisor
4. File ID: Year No. Sequence

1. Campus: 28
2. Date and time of accident: Mo. Day Year Time
3. Date of report: Mo. Day Year

5. Did accident involve personal injury: A) Yes B) No
6. Victim status: A) Student B) Faculty/Staff C) Patrol Officer D) FSA E) Patient F) Vendor G) Visitor H) Other (specify)

7. Name of office/department where employee is regularly assigned:

8. Sex: A) Female B) Male
9. Date of birth: Mo. Day Year
10. Name of victim (PRINT LAST NAME, FIRST, MIDDLE)

11. Marital status: A) Single B) Married C) Separated D) Divorced E) Unknown
12. Social Security Number:
Local address: Tel.

13. Job title and grade:
Home Address: Tel.

14. Employment date: Mo. Day Year
15. Was victim in authorized area: A) yes B) No C) Unknown
Tel.

16. Reporter of accident: A) Faculty/Staff B) Victim C) Other (specify)
17. Name of reporter of accident: (PRINT LAST NAME, FIRST, MIDDLE)

18. General area of occurrence: A) Dorm B) Dining hall C) Student union D) Academic E) Gym F) Admin. G) Maint. Bldg. H) Road I) Parking Lot J) Grounds K) Hospital L) Other
Address: Tel.

19. Specific area of occurrence: Room:

20. If physical injury, part of body injured: (ONE ONLY, MOST SERIOUS)
A) Abdomen B) Ankle C) Arm D) Back E) Chest F) Elbow G) Eye H) Face I) Finger J) Foot K) Hand L) Head M) Hip N) Knee O) Leg P) Lip Q) Neck R) Nose S) Shoulder T) Spine U) Teeth V) Thigh W) Toes X) Trunk Y) Wrist Z) Other (specify)
21. If physical injury, type of injury: (SELECT ONE ONLY)
A) Abrasion B) Amputation C) Bruise D) Burn E) Burn (chem.) F) Concussion G) Cut H) Dislocation I) Fracture J) Laceration K) Puncture L) Swelling M) Tooth (broken) N) Sprain O) Strain P) Other (specify)

22. If physical injury, extent: A) Fatal B) Major C) Minor
23. If physical injury, nature: A) Temporary B) Permanent
24. Accident: A) Athletic B) Academic C) Job related D) Other

25. Were safeguards provided: A) Yes B) No
26. Were safeguards in use: A) Yes B) No

27. Are there witnesses: (List in narrative) A) Yes B) No
28. Medical assistance rendered: A) First aid by staff B) Infirmary C) Hospital D) Ambulance E) Other

29. Name and address of physician:
30. Name and address of hospital:

31. Has employee returned to work: A) yes B) No If yes, date: Mo. Day Year
32. Employee have restricted duties: A) Yes B) No

33. Supervisor notified: A) Yes B) No Date and time: Mo. Day Year Time
34. Name of Supervisor:

NARRATIVE: (Only give a brief description of who, what, when, where, how, etc.) List witnesses names and addresses.

Report completed by: Title: Date:
Safety Supervisor's signature: Title: Date: