



**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 _____ 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