Bloomsburg University of Pennsylvania

Accident/Incident/Injury Report

Date of Report: _________________

Please submit to the office of Human Resources by the end of the workday following the accident, incident, or injury. This form is to be completed by the person injured and/or involved in the accident/incident.

Is the person completing this form a:  ☐ Student  ☐ Employee  ☐ Visitor  ☐ Student Employee

Please Print or Type Responses

Date of Injury: ____________     Time of Injury: _____________

Date Reported to University Representative: _________________

Name: (Last) _____________________________ (First) ______________________________

Date of Birth: __________         Male     Female   Telephone Number: ____________

Street Address: ________________________________________

City: ___________________    County: ___________________     State:______  Zip: ________

Physician’s Name: ______________________________ Telephone Number: _______________

Address: ______________________________________________________________________

Normal Starting Time: _________  Payroll Classification: __________ Date of Hire: _________

Did you complete a normal shift or teaching assignment on day of injury?         Yes      No

First day away from work due to injury (date): ________________

Date returned to work following injury:  _____________________

Did you receive full pay for day of injury?   Yes    No    Name of supervisor: ________________

Where did the incident occur? (specific location):  ___________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

____________________________________________________________________________________________

Describe accident/incident (be specific and use additional paper if needed): _______________________________

____________________________________________________________________________________________

____________________________________________________________________________________________
What were you doing at the time of the accident/incident?
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
Identify any unsafe condition(s): _________________________________________________________________
____________________________________________________________________________________________
Identify all equipment, materials, or chemicals employee was using when accident or illness exposure occurred:
___________________________________________________________________________________________
____________________________________________________________________________________________
How would you prevent this accident/incident from recurring? _________________________________________
____________________________________________________________________________________________
Did anyone witness the accident/ incident?      Yes       No
If yes, give names: ____________________________________________________________________________
Did you sustain an injury?   Yes   No
If yes, what body part was affected? ______________________________________________________________
____________________________________________________________________________________________
Left Side      Right Side      N/A
Please describe the injury:
____________________________________________________________________________________________
____________________________________________________________________________________________
Initial treatment:                                                                                   
□ No Medical Treatment  □ Minor Treatment by Employee  □ Clinic/Hospital  
□ Panel Physician  □ Employee Physician  □ Emergency Care  □ Hospitalization for More Than 24 Hours
Did you sustain damage to personal property?     Yes     No
If yes, describe:_______________________________________________________________________________
Employee Signature: ______________________________  Date:______________________