Injury Report Form

TO BE COMPLETED BY INJURED PERSON:  Today’s Date: _____________

Name ___________________________________________ PLU ID#: _____________

☐ Employee  ☐ Student  ☐ Student Employee  ☐ Visitor

Address: ___________________________________________ Phone: ______________

Date of Accident: __________ Time: __________ Location: __________________________

Type of injury: _______________________________________

Part of body injured: ___________________________________

Date reported: __________ Time: __________ Reported to: __________________________

Description of accident (Include activities just prior to accident): ______________________
____________________________________________________________________________
____________________________________________________________________________

Contributing unsafe conditions: ________________________________________________
____________________________________________________________________________

Tools, chemicals, or equipment involved: __________________________________________

Suggestions for correcting conditions: ____________________________________________
____________________________________________________________________________

Witness (name, address, and phone number): ______________________________________

Treatment:  ☐ First aid  ☐ Sent home  ☐ Emergency room
☐ Sent to physician (name): ______________________________________________________
☐ Admitted to hospital (name): __________________________________________________

Medical attention received: _____________________________________________________

Related previous injuries: _______________________________________________________

Signature: ___________________________________________ Date: ______________

Employees and Student Employees
Complete reverse side of this page
Return to Human Resources Office

Students and Visitors
Complete Front side only and return to
Campus Safety Office, Harstad G-28
TO BE COMPLETED BY PLU EMPLOYEES ONLY:

Employee Work Phone #: ___________________________ Work Start Time: ________

Department: ___________________________ Position: ___________________________

☐ Full time ☐ Part time ☐ Temporary ☐ Student

Could this accident have aggravated a pre-existing injury or illness? ☐ Yes ☐ No
If yes, explain: _________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

TO BE COMPLETED BY EMPLOYEE’S SUPERVISOR:
(Please complete as soon as possible. Report lost time to date if necessary.)

Work time lost: ________ Date(s) of lost time: _______________________________________

Date returned to work: __________________ Light duty days: ___________________________

Describe how and why accident occurred: ___________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Was the accident area inspected? ☐ Yes ☐ No Comments: ______________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

List actions taken to prevent similar accidents in the future (include target date, completion date,
and name of person responsible):

1) _____________________________________________________________

2) _____________________________________________________________

3) _____________________________________________________________

Comments: _________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Supervisor name (print) __________________________________________ Date: __________

Copies will be sent to: Safety Coordinator, Risk Management, and Campus Safety