



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: _____

PLU Initial Hire Date: _____

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 after the accident as possible. Report lost time/light duty 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) _____

Supervisor signature: _____ Date: _____

Copies will be sent to: Environmental, Health & Safety and Risk Management