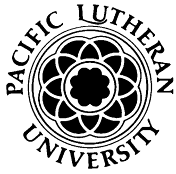

Injury Report Form

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 after the accident 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) ____

Supervisor signature: ____ Date: ___________________

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

Revised February 2008