Injury Report Form

TO BE COMPLETED BY INJURED PERSON:

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 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