

Student/Visitor Incident Reporting/Investigation Form

INCIDENT INFORMATION

Date of Incident	Time	Day of Week <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> T <input type="checkbox"/> W <input type="checkbox"/> T <input type="checkbox"/> F <input type="checkbox"/> S	Location of Incident (Bldg., Room Number)
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INJURED PERSON

Name:		Address:	
Age:	Phone:		
<input type="checkbox"/> Student <input type="checkbox"/> Visitor	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Banner ID (If applicable):	

PERSON REPORTING INCIDENT

Position/Title (e.g., Professor, PI, Technician, Student):				
Nature of Injury	<input type="checkbox"/> Abrasion/Scratch	<input type="checkbox"/> Amputation	<input type="checkbox"/> Asphyxiation	<input type="checkbox"/> Bite
<input type="checkbox"/> Bruise	<input type="checkbox"/> Burn	<input type="checkbox"/> Chemical Reaction	<input type="checkbox"/> Concussion	<input type="checkbox"/> Cut/Laceration
<input type="checkbox"/> Dislocation	<input type="checkbox"/> Fracture	<input type="checkbox"/> Poisoning	<input type="checkbox"/> Puncture	<input type="checkbox"/> Scalds
<input type="checkbox"/> Shock (elect.)	<input type="checkbox"/> Sprain	<input type="checkbox"/> Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>
Injured Part of Body				
<input type="checkbox"/> Abdomen	<input type="checkbox"/> Ankle	<input type="checkbox"/> Arm	<input type="checkbox"/> Back	<input type="checkbox"/> Chest
<input type="checkbox"/> Ear	<input type="checkbox"/> Elbow	<input type="checkbox"/> Eye	<input type="checkbox"/> Face	<input type="checkbox"/> Finger
<input type="checkbox"/> Foot	<input type="checkbox"/> Hand	<input type="checkbox"/> Head	<input type="checkbox"/> Knee	<input type="checkbox"/> Leg
<input type="checkbox"/> Mouth	<input type="checkbox"/> Nose	<input type="checkbox"/> Scalp	<input type="checkbox"/> Tooth	<input type="checkbox"/> Wrist
<input type="checkbox"/> Other (Specify):				
Treatment	Name and Address of Treating Physician or Facility:			
<input type="checkbox"/> First Aid				
<input type="checkbox"/> Student Health Services				
<input type="checkbox"/> Emergency Room				
<input type="checkbox"/> Hospitalization				
Location of Incident	<input type="checkbox"/> Athletic Field	<input type="checkbox"/> Auditorium	<input type="checkbox"/> Cafeteria	<input type="checkbox"/> Classroom
<input type="checkbox"/> Corridor	<input type="checkbox"/> Gymnasium	<input type="checkbox"/> Laboratories	<input type="checkbox"/> Locker Room	<input type="checkbox"/>

DESCRIPTION OF INCIDENT – NON - LABORATORY

How did incident happen? What was the student doing? Where was Student? List specifically unsafe acts and unsafe conditions existing. Please specify.

DESCRIPTION OF INCIDENT – LABORATORY

Principal Investigator/Instructor:		Laboratory Room Number:		
How did incident happen? What chemicals were involved? Were Material Safety Data Sheets (MSDSs) given to students? Were possible reactions of chemicals discussed? Were personal protective equipment (PPE) worn? Was the experiment in written form for students to follow? Is this a new procedure?				
<input type="checkbox"/> MSDS Given to Student for Exposure Information		<input type="checkbox"/> Student Referred to SHS	<input type="checkbox"/> SHS Called or Notified About Incident	
PPE:	<input type="checkbox"/> Safety glasses/goggles	<input type="checkbox"/> Lab coat	<input type="checkbox"/> Closed-toed shoes	<input type="checkbox"/> Other:
Emergency Equipment Used:	<input type="checkbox"/> Fire Extinguisher	<input type="checkbox"/> Emergency eyewash/shower	<input type="checkbox"/> Other:	

Remarks: Corrective Action Taken/What recommendations do you have for preventing other accidents of this kind?

DAMAGED PROPERTY

Property, Equipment, or Material Damaged:

Describe Damage:

Object or Substance Inflicting Damage:

Describe what happened (attach photographs or diagrams if necessary)

Root Cause of Incident (Check All that Apply)

Unsafe Acts

Unsafe Conditions

Management Deficiencies

Improper work technique

Poor workstation design or layout

Lack of written procedures or policies

Safety rule violation

Congested work area

Safety rule not enforced

Improper PPE or PPE not used

Hazardous substances

Hazards not identified

Operating without authority

Fire or explosion hazard

PPE unavailable

Failure to warn or secure

Inadequate ventilation

Insufficient student training

Operating at improper speeds

Improper material storage

Insufficient supervision

Improper loading or placement

Insufficient knowledge of task

Inadequate equipment

Improper Lifting

Slippery conditions

Other:

Horseplay

Poor housekeeping

Drug or alcohol use

Insufficient lighting

Unnecessary haste

Improper tools or equipment

Other:

Other:

1. OTHER INDIVIDUALS INVOLVED/WITNESSES

Name:

Phone:

Address:

Where were you, and what were you doing at the time of the incident?

2. OTHER INDIVIDUALS INVOLVED/WITNESSES

Name:

Phone:

Address:

Where were you, and what were you doing at the time of the incident?

Additional Remarks:

Principal Investigator/Supervisor Signature: _____

Please print the completed form and sign. Send signed form to the Safety Office.

Save form and email to safety@uncp.edu