INCIDENT REPORT INSTRUCTIONS

ALL REPORTS MUST BE FILED PROMPTLY
WITH THE RISK MANAGER/HUMAN RESOURCES OFFICE
WITHIN 24 HOURS OF THE INCIDENT.
IF THE INCIDENT OCCURS DURING THE EVENING OR WEEKEND,
THE REPORT IS TO BE DELIVERED BY 8:30 a.m. THE NEXT WORKING DAY.

Complete this report whenever you are aware of any property damage, personal injury, or possibility of personal injury (an incident where there is no apparent injury, but a person may later be affected as a result of it).

Part A

This section must be completed by the following individuals, as appropriate, indicating the status of each person who provides information:

Injured Party
Witness to the Accident
Employee
Supervisor
Student
Guest

Always send the original form to the Risk Manger/Human Resources Office as noted at the bottom of the form. You may keep copies for you won record if you wish. Please print (or type) and answer all pertinent questions.

The form is designed for the report of both personal injury and property damage incidents. If the wording of a question doesn't specifically fit the incident, please provide enough information so someone not present could understand what happened.

Under "Additional Remarks" some notation of the situation of the person involved or circumstances of the incident is usually helpful.

Part B SUPERVISOR'S REPORT OF ACCIDENT INVESTIGATION

To be completed by area supervisor.

Paul Smith's College
THE COLLEGE OF THE ADIRONDACKS

1. INJURED'S NAME _____SSN_____-_____-_____

ADDRESS _____PHONE# _____

2. INCIDENT: DATE _____/_____/_____ TIME _____ a.m. p.m.

3. WHERE DID THE INCIDENT OCCUR? _____

4. WAS INJURED WORKING FOR PAY AT THE TIME OF INJURY? YES / NO
(Circle One) Employee Student Guest

5. INJURED'S DEPARTMENT _____SUPERVISOR_____

6. NAME(S), ADDRESS(ES) AND PHONE NUMBER(S) OF WITNESS(ES) _____
_____

7. STATE NATURE OF INJURY AND PART OF BODY AFFECTED _____
_____

8. WAS MEDICAL CARE PROVIDED? YES / NO
IF YES:
A. WHEN? _____
B. TO WHAT EXTENT? _____
C. BY WHOM? _____
D. WHERE? _____
E. TRANSPORTED BY WHOM? _____AND HOW? _____

9. WHEN DID YOU FIRST KNOW OF THE INJURY? _____

10. PLEASE DESCRIBE FULLY WHAT INJUED PARTY WAS DOING WHEN THE INCIDENT OCCURRED AND DETAILS OF HOW AND WHERE INCIDENT HAPPENED _____
_____
_____

11. IF YOU ARE AWARE OF ANY RULES AND REGULATIONS NOT BEING FOLLOWED AT THE TIME OF THE INCIDENT, PLEASE STATE: _____
_____

12. ADDITIONAL REMARKS: _____
_____

_____/_____/_____
NAME OF PERSON FILLING OUT REPORT SIGNATURE DATE

PSC Office Use
Seen in PSC Health Services ☐ Yes ☐ No Date _____ By_____

Referral To_____ Remarks_____

SUBMIT THIS REPORT WITHIN ONE WORKING DAY
TO THE RISK MANAGER/HUMAN RESOURCES OFFICE

HR DEPARTMENT INFORMATION: WAS INJURED PAID IN FULL FOR THIS DAY? YES / NO
DAYS/HOURS LOST DUE TO INJURY?_____ DATE/TIME RETURNED TO WORK? _____

SUPERVISOR'S REPORT OF WORK INJURY

The unsafe acts of persons and the physical conditions that contribute to the accidents can be corrected only when they are known in detail. As Supervisor, it is your responsibility to find and **describe** them, and to **state a remedy** for them in this report.

Name of Injured Person _____

Hours he/she worked on day of injury _____
Regular hours/day_____ Regular hours/week _____ Regular days worked _____

Employee's Job Title _____ Time on Present Job _____

Department/Section in which Employee works _____

Where did the accident happen? _____

Describe the injury. (Be specific—burned left forearm, cut on forehead near right eye, etc.)
_____

_____

How did the injury occur? (State what the injured party was doing and the circumstances leading to injury)
_____

_____

Who (if anyone) gave First Aid, if any? _____

Describe the location of the accident as clearly as possible. _____

_____

What could be done to prevent a similar injury? _____

_____

Your Name _____ Today's Date _____/_____/_____
Supervisor

Report Reviewed and Approved By _____

Date _____/_____/_____