STUDENT ACCIDENT/INCIDENT REPORT

Location of Accident/Incident: _____ _____	Date & Time: ☐ AM ☐ PM
Student Name: Check box if student is an employee ☐ _____	Student Phone Number:
Faculty Name & Department Head Name: _____	Faculty Phone Number:
Briefly describe the accident/incident _____ _____ _____	
Were You Injured? ☐ YES ☐ NO	Briefly describe injury: _____ _____ _____
Received medical treatment? ☐ YES ☐ NO	Dr. Name: _____ Address: _____ _____
Statement Attached	Witness Name & Phone Number
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UNSAFE CONDITIONS: Was there an unsafe condition? _____ _____	
UNSAFE ACTS: What did anyone do or fail to do that led to this accident/incident? _____ _____	
RECOMMENDATIONS: What action has been or should be taken to prevent a similar accident/incident from occurring? _____ _____	
Student Signature:	Date:
Department Recommendations: _____ _____	
Faculty/Dept Head Signature:	Date: