

# NDSCS ACCIDENT/INJURY REPORT

This form is to be completed immediately by persons (employee, work study, student or visitor) involved in incidents/accidents which occur at NDSCS. Return completed report within 24 hours of incident to: NDSCS Safety Coordinator

Date: \_\_\_\_\_ Name: \_\_\_\_\_ SS #: \_\_\_\_\_

Employee \_\_\_\_\_ Work Study \_\_\_\_\_ Student \_\_\_\_\_ Visitor \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Required Info: \*Age: \_\_\_\_\_ \*Gender: \_\_\_M \_\_\_F

Local/Campus Address: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

Local/Campus Phone: \_\_\_\_\_ Permanent Phone: \_\_\_\_\_

Location Occurred:(bldg., dept, room) \_\_\_\_\_

Date/Time Occurred: \_\_\_\_\_ Date/Time Reported: \_\_\_\_\_

Primary Complaint (circle all that apply):

- 1-Head
- 2-Face
- 3-Eye
- 4-Neck
- 5-Chest
- 6-Back
- 7-Shoulders
- 8-Entire Body
- 9-Elbow-Lower Arm-Hand
- 10-Abdomen-Pelvis
- 11-Hip-Upper leg
- 12-Knee-Lower leg
- 13-Other \_\_\_\_\_

Physical Emotional

Status (circle all that apply):

- 1-Unconscious
- 2-Alert
- 3-Incoherent
- 4-Other \_\_\_\_\_

Type of Physical Complaint (circle all that apply):

- 1-Scrape
- 2-Head Injured
- 3-Fracture-Dislocation
- 4-Minor Bleeding
- 5-Severe Bleeding
- 6-Complaint of Pain
- 7-Strain
- 8-Minor Burn
- 9-Chemical Burn
- 10-Severe Burn
- 11-Bruise
- 12-Amputation
- 13-Sprain
- 14-Other \_\_\_\_\_

Apparent Contributing Factors (circle):

- 1-Inattention
- 2-Lost Consciousness
- 3-Medical Condition
- 4-Medication
- 5-Alcohol
- 6-Drugs
- 7-Athletic
- 8-Fall
- 9-Struck by Object
- 10-Other

Photos: Yes No

Refused Treatment: Yes No

Treated By: \_\_\_\_\_

Transported By: \_\_\_\_\_

Describe Other: \_\_\_\_\_ Transported To: \_\_\_\_\_

Describe incident:(attach additional sheets as necessary) \_\_\_\_\_

Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Refusal of Medical Aid Release: (For use when ambulance personnel are not present)

I hereby refuse treatment & acknowledge that treatment was advised by the officer, ambulance crew, health services or physician. I hereby release NDSCS and its agents from liability for respecting and following my expressed wishes.

Person Refusing Medical Assistance Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Instructor, Supervisor or Person in Charge of Building (Complete immediately):**

Was person trained in safe operating procedures: \_\_\_\_\_Y \_\_\_\_\_N \_\_\_\_\_NA

List personal protective equipment being used: \_\_\_\_\_

Description of incident:(attach additional sheets as necessary)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What has been done to prevent similar incident or accident: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

**\*\* Get statements/information from all witnesses about incident\*\*** (attach additional sheets as necessary using the same format)

<u>Witness</u>	<u>Name</u>	<u>Address</u>	<u>Phone (Home)</u>	<u>Phone (local)</u>
#1	_____	_____	_____	_____

#2	_____	_____	_____	_____
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Witness describe incident: (attach additional sheets as necessary) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Witness #1 Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Witness #2 Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Student Health Services Complete:**

Injury: \_\_\_\_\_ Treatment: \_\_\_\_\_

Referred to: Clinic \_\_\_\_\_ Hospital \_\_\_\_\_

Employee/Student may return to work/classroom/lab/shop on:

\_\_\_\_\_ Without work/classroom/lab/shop restrictions

\_\_\_\_\_ With the following work/classroom/lab/shop restrictions: \_\_\_\_\_

Student Health Services Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Safety Coordinator Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Revision Date: 11/15/2006