

STATE UNIVERSITY OF NEW YORK
REPORT OF ACCIDENT OR INJURY
(OTHER THAN A MOTOR VEHICLE ACCIDENT)

1. Campus: 28	2. Date and time of accident: Mo. Day Year Time	3. Date of report: Mo. Day Year	To be completed by Safety Supervisor			
5. Did accident involve personal injury: A) Yes B) No		6. Victim status: A) Student B) Faculty/Staff	C) Patrol Officer D) FSA	E) Patient F) Vendor	G) Visitor H) Other (specify)	4. File ID: Year No. Sequence

7. Name of office/department where employee is regularly assigned:

8. Sex: A) Female B) Male	9. Date of birth: Mo. Day Year	10. Name of victim (PRINT LAST NAME, FIRST, MIDDLE)
11. Marital status: A) Single B) Married C) Separated D) Divorced E) Unknown	12. Social Security Number:	Local address:

13. Job title and grade:	14. Employment date: Mo. Day Year	15. Was victim in authorized area: A) yes B) No C) Unknown	Home Address:	Tel:
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16. Reporter of accident: A) Faculty/Staff B) Victim C) Other (specify)	17. Name of reporter of accident: (PRINT LAST NAME, FIRST, MIDDLE)
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18. General area of occurrence: A) Dorm B) Dining hall C) Student union D) Academic E) Gym F) Admin. G) Maint. Bldg. H) Road I) Parking Lot J) Grounds K) Hospital L) Other	Address:
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19. Specific area of occurrence: Room:	Tel:
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20. If physical injury, part of body injured: (ONE ONLY, MOST SERIOUS) A) Abdomen B) Ankle C) Arm D) Back E) Chest F) Elbow G) Eye H) Face I) Finger J) Foot K) Hand L) Head M) Hip N) Knee O) Leg P) Lip Q) Neck R) Nose S) Shoulder T) Spine U) Teeth V) Thigh W) Toes X) Trunk Y) Wrist Z) Other (specify)	21. If physical injury, type of injury: (SELECT ONE ONLY) A) Abrasion B) Amputation C) Bruise D) Burn (chem.) E) Burn (chem.) F) Concussion G) Cut H) Dislocation I) Fracture J) Laceration K) Puncture L) Swelling M) Tooth (broken) N) Sprain O) Strain P) Other (specify)
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22. If physical injury, extent: A) Fatal B) Major C) Minor	23. If physical injury, nature: A) Temporary B) Permanent	24. Accident: A) Athletic B) Academic C) Job related D) Other
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25. Were safeguards provided: A) Yes B) No	26. Were safeguards in use: A) Yes B) No
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27. Are there witnesses: (List in narrative) A) Yes B) No	28. Medical assistance rendered: A) First aid by staff B) Infirmary C) Hospital D) Ambulance E) Other
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29. Name and address of physician:	30. Name and address of hospital:
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31. Has employee returned to work: A) yes B) No If yes, date: Mo. Day Year	32. Employee have restricted duties: A) Yes B) No
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33. Supervisor notified: A) Yes B) No Date and time: Mo. Day Year Time	34. Name of Supervisor:
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NARRATIVE: (Only give a brief description of who, what, when, where, how, etc.) List witnesses names and addresses.

Report completed by:	Title:	Date:
Safety Supervisor's signature:	Title:	Date: