FREDONIA
STATE UNIVERSITY OF NEW YORK

Report of Accident or Injury

Part 1 – Personal Information

Last Name	First Name	Middle Name	
Home Address - Street	City	State	Zip Code
Home Telephone #	Work Telephone #	Negotiating Unit: ☐ CSEA ☐ UUP ☐ PEF ☐ MC ☐ PBANYS ☐ NYSCOPBA	
Job Title	Department	Supervisor	
Shift Start Time (am/pm)	Shift End Time (am/pm)	Scheduled Work Days: ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun	

Part 2 – Incident Information

Accident Date

Accident Time (am/pm)

Were you working overtime?
☐ Yes ☐ No

Did you leave work?
☐ Yes ☐ No

Have you returned to work?
☐ Yes ☐ No
If YES, date and time:

Were safeguards in use?
☐ Yes ☐ No

Supervisor notified?
☐ Yes ☐ No

Did you receive medical treatment?
☐ Yes ☐ No
If YES, on what date?

Medical Treatment Provided:
☐ First aid on site
☐ Hospital
☐ Personal physician

Did you go to the Emergency Room?
☐ Yes ☐ No

Were you admitted to the hospital?
☐ Yes ☐ No

Exact location of accident (building, room #, parking lot #)

Part of body injured: (Be specific; include left or right side, which digit [1-5], etc.)

Type of injury: (e.g. bruise, burn, cut, fracture, puncture, swelling, strain, sprain, etc.)

What tools, equipment, objects, or substances were involved?

Description of Incident: (Include causal factors that contributed to the accident. Please be specific and include as many details as possible.)

Did your supervisor witness the accident/injury happen? ☐ Yes ☐ No
Please provide the name(s) of any witness(es):

Name of Doctor/Hospital that provided treatment for this injury, if applicable:

Address of Doctor/Hospital that provided treatment for this injury, if applicable:

Part 3 – Report Completion

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

Agency 28180

File ID: Year No. Sequence

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