

ACCIDENT REPORT

- ACCIDENT WITH AN INJURY (NO MEDICAL AID)
 ACCIDENT WITH AN INJURY (MEDICAL AID)
 INCIDENT (ACCIDENT WITH NO INJURY)

IDENTIFICATION	LAST NAME		FIRST NAME		SOCIAL INSURANCE NUMBER	
	LOCAL ADDRESS			POSTAL CODE	LOCAL PHONE NUMBER	
	DEPARTMENT		JOB TITLE		STATUS AT TIME OF ACCIDENT <input type="checkbox"/> EMPLOYEE <input type="checkbox"/> VOLUNTEER <input type="checkbox"/> STUDENT <input type="checkbox"/> CONTRACTOR OR SERVICE PROVIDER <input type="checkbox"/> EMPLOYED ON CAMPUS (NOT LU)	
INJURY/FIRST AID/HEALTH CARE	DATE/TIME ACCIDENT INJURY NOTED: DAY MONTH YEAR AM PM		DATE/TIME REPORTED TO SUPERVISOR: DAY MONTH YEAR AM PM		NAME & DEPARTMENT OF SUPERVISOR TO WHOM REPORTED:	
	IF INJURY/DISEASE WAS NOT REPORTED IMMEDIATELY, PROVIDE REASON FOR DELAY:					
	DATE/TIME FIRST AID (INCL. SELF TREATMENT): DAY MONTH YEAR AM PM		FIRST AID PROVIDED BY:			
	NATURE OF INJURY (SPECIFY TYPE OF INJURY, PART OF BODY AFFECTED):					
	NATURE OF INITIAL FIRST AID, INCLUDING ANY SELF-TREATMENT:					
	REFERRED TO/ SOUGHT HEALTH CARE: <input type="checkbox"/> YES <input type="checkbox"/> NO		TRANSPORTED TO: <input type="checkbox"/> HOSPITAL <input type="checkbox"/> CLINIC <input type="checkbox"/> HOME <input type="checkbox"/> N/A		TRANSPORTED BY: <input type="checkbox"/> AMBULANCE <input type="checkbox"/> TAXI <input type="checkbox"/> OWN VEHICLE <input type="checkbox"/> OTHER	
	DATE/TIME INITIAL HEALTH CARE: DAY MONTH YEAR AM PM		HEALTH CARE PROVIDED BY (NAME) AT (LOC'N):		CURRENT/CONTINUING HEALTH CARE PROVIDED BY/AT:	
ACCIDENT DESCRIPTION	LOCATION OF OCCURENCE: (Include building and room number, if outdoors give closest building, parking lot #. Include floor plans if necessary):					
	DESCRIPTION OF HOW THE ACCIDENT OCCURED, INCLUDING RELEVANT EVENTS LEADING UP TO THE ACCIDENT (USE ADDITIONAL PAGES, IF REQUIRED):					

ACCIDENT DESCRIPTION CONT'D				
	CORRECTIVE ACTIONS TAKEN OR SUGGESTED:			
	<input type="checkbox"/> ADDITIONAL PAGES OR SUPPLEMENTAL INFORMATION IS ATTACHED			
	IF SPECIFIC EQUIPMENT OR MATERIALS WERE INVOLVED, PLEASE DESCRIBE, INCLUDING SIZE, WEIGHT AND COMPOSITION:			
NAME OF WITNESS(ES):				
SIGNATURES	SIGNATURE:	<input type="checkbox"/> REPORT BY PERSON INVOLVED <input type="checkbox"/> WITNESS REPORT <input type="checkbox"/> SUPERVISOR'S REPORT	DAY MONTH YEAR	AM PM
	BY SIGNING THIS DOCUMENT, I CONFIRM THAT THIS STATEMENT IS COMPLETE AND CORRECT			
	SIGNATURE OF PERSON TAKING REPORT	TITLE & DEPARTMENT OF PERSON TAKING REPORT	DAY MONTH YEAR	AM PM
DOH=	DOC=	#YEARS CURRENT	DOB=	