

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 4. File ID: Year No. Sequence			
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 _____)			
7. Name of office/department where employee is regularly assigned: _____													
6. 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: _____ Tel: _____							
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: _____					
16. Reporter of accident: A) Faculty/Staff B) Victim C) Other (specify _____)						17. Name of reporter of accident: (PRINT LAST NAME, FIRST, MIDDLE)							
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				Room: _____				Address: _____ Tel: _____					
19. Specific area of occurrence:						21. If physical injury, type of injury: (SELECT ONE ONLY)							
20. If physical injury, part of body injured: (ONE ONLY, MOST SERIOUS)						22. If physical injury, extent:							
A) Abdomen F) Elbow K) Hand P) Lip U) Teeth B) Ankle G) Eye L) Head Q) Neck V) Thigh Z) Other (specify _____ C) Arm H) Face M) Hip R) Nose W) Toes D) Back I) Finger N) Knee S) Shoulder X) Trunk E) Chest J) Foot O) Leg T) Spine Y) Wrist						A) Fatal B) Major C) Minor A) Temporary B) Permanent							
23. If physical injury, nature: A) Temporary B) Permanent				24. Accident: A) Athletic B) Academic C) Job related D) Other				25. Were safeguards provided: A) Yes B) No					
26. Were safeguards provided: A) Yes B) No				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					
29. Name and address of physician: _____						30. Name and address of hospital: _____							
31. Has employee returned to work: A) yes B) No						32. Employee have restricted duties: A) Yes B) No							
33. Supervisor notified: A) Yes B) No						34. Name of Supervisor: _____							

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: