CS-13

Accident / Injury Reporting

SUNY CANTON

1. Date and Time of Accident: Mo: Day: Year: Time:

2. Date of Report: Mo: Day: Year:

3. Did accident involve personal injury: A) Yes B) No

4. Injured: A) Student B) Faculty/Staff C) CA D) Vendor E) Visitor F) Other (specify)

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

6. Sex: A) Female B) Male

7. Date of Birth: Mo: Day: Year:

8. Name of Injured (PRINT Last, First, Middle)

Local Address:

Telephone:

Home Address:

Telephone:

9. Job title (include Student Workers injured while working):

10. Was injured in authorized area: A) Yes B) No C) Unknown

11. Reporter of Accident (Person reporting to you): A) Faculty/Staff B) Injured C) Other (specify)

12. Name of reporter of accident:
PRINT Last, First, Middle:
Local address:
Telephone:

13. General area of occurrence:
A) Residence Hall
B) Dining Hall
C) Campus Center
D) Academic
E) Gym
F) French Hall
G) Maint. Building
H) Road
I) Parking Lot
J) Grounds
K) Other

14. Specific area of occurrence:
Room Number:

15. If physical injury, part of body injured: (ONLY ONE MOST SERIOUS)

A) Abdomen	G) Eye	M) Hip	R) Nose	X) Trunk
B) Ankle	H) Face	N) Knee	S) Shoulder	Y) Wrist
C) Arm	I) Finger	O) Leg	T) Spine	Z) Other, specify
D) Back	J) Foot	P) Lip	U) Teeth	
E) Chest	K) Hand	Q) Neck	V) Thigh	
F) Elbow	L) Head	R) Nose	W) Toes	

Please list the side of the body injured. (if applicable) L or R

16. Accident: A) Athletic B) Academic C) Job related D) Other

17. Are there witnesses: (List in narrative) A) Yes B) No

18. If Physical Injury, type of injury (SELECT ONE ONLY)

A) Abrasion	F) Concussion	K) Puncture	P) Other, specify
B) Amputation	G) Cut	L) Swelling	
C) Bruise	H) Dislocation	M) Tooth (broken)	
D) Burn	I) Fracture	N) Sprain	
E) Burn (chem)	J) Laceration	O) Strain	

19. Were safeguards provided: A) Yes B) No

20. Were safeguards in use: A) Yes B) No

21. Medical assistance rendered: A) First aid by staff B) Infirmary C) Hospital D) Ambulance E) Other

22. Name and address of hospital:

23. Name and address of physician:

24. Has employee returned to work: A) Yes B) No
If yes, date: Mo: Day: Year:

25. Supervisor notified: A) Yes B) No
Date and Time: Mo: Day: Year: Time:

26. Employee have restricted duties: A) Yes B) No

27. 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:

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FORWARD TO HUMAN RESOURCES