

Report of Injury

It is the responsibility of each supervisor to ensure that this report is filed with Emergency Management and Safety within 24 business hours of becoming aware of an incident or hazard related to SIUE facilities or operations.

Please complete only those sections that are applicable to the incident.

I. PERSON INVOLVED IN INCIDENT	Name (Last, First, Mi)		Sex <input type="checkbox"/> F <input type="checkbox"/> M	E-Mail
	Date of Birth			Cougar ID #:
	Address (Local)			Phone (W) _____ (H) _____
	Status At Time Of Incident <input type="checkbox"/> Employee <input type="checkbox"/> Visitor <input type="checkbox"/> Student <input type="checkbox"/> Other (Specify):	If An Employee, Give Job Title And Department		If A Visitor, State Purpose Of Campus Visit
IF OTHERS WERE INVOLVED, ATTACH ADDITIONAL COPIES OF THIS FORM FOR EACH PERSON.				
Were the Police Notified? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Did Incident Arise Out Of And In The Course Of University Employment? <input type="checkbox"/> Yes <input type="checkbox"/> No				
II. INCIDENT/ OR HAZARD DESCRIPTION	Place Where Accident/Incident Occurred Or Hazard Is Located	Date & Time Of Incident	Name Of Area Supervisor Where Incident Occurred Or Hazard Is Located.	
	Describe Activity Being Performed By Person Involved In Incident (I.E. Driving Truck, Lifting Crate, Etc.)			
	Fully Describe Incident/Hazard (Attach Additional Sheets If Necessary.)			
	List Any Witness Present Name	Address		Phone (W) _____
Additional Witness(es) Present Name	Address		Phone (W) _____	
III. INJURY	Did This Incident Result In Injury To The Person Involved? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	IF INJURY OR ILLNESS RESULTS FROM AN INCIDENT ARISING OUT OF AND IN THE COURSE OF UNIVERSITY EMPLOYMENT, THE INJURED PERSON OR THEIR SUPERVISOR (If injured person is unable) MUST CALL CareSys, Inc. AT 1-800-773-3221 AND REPORT THE INJURY OR ILLNESS and CALL CATHY MEYERS AT (618) 650-2190			
	Describe Nature And Scope Of Personal Injury, If Any _____ _____			
Was Medical Care Sought? <input type="checkbox"/> No <input type="checkbox"/> Yes: Place & Date of Treatment				
IV. PROPERTY DAMAGE	Describe Property Damage, If Any			
V. SIGNATURE	Printed Name Of Person Completing Form		Job Title/Occupation	
	Signature Of Person Completing Form _____ Date _____		Phone Number (W) _____ (H) _____	