|  |  |  |
| --- | --- | --- |
| **Report of Injury** | **Emergency Management and Safety**Campus Box 1657<http://www.siue.edu/emergencymanagement>/ (618) 650-3584 Fax (618) 650-2196 | **\_\_\_\_\_\_\_\_\_\_\_\_****Case Number** |

***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** □ F □ M | E-Mail |
| Date of Birth |  | **Cougar ID #:** |
| **Address** (Local) | **Phone** (W) \_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_ (H) \_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_ |
| **Status** At Time Of Incident□ Employee □ Visitor□ Student □ 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? □ Yes □ NoDid Incident Arise Out Of And In The Course Of University Employment? □ Yes □ No |
| **II.****INCIDENT/****OR HAZARD****DESCRIPTION** | **Place** Where Accident/Incident Occurred Or Hazard Is Located | Date & TimeOf Incident | **Name Of Area Supervisor** Where IncidentOccurred 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** PresentName | Address | Phone (W) \_\_\_\_ \_\_\_ \_\_\_\_\_\_ |
| **Additional Witness(es)** PresentName | Address | Phone (W) \_\_\_\_ \_\_\_ \_\_\_\_\_\_ |
| **III.**INJURY | Did This Incident Result In Injury To The Person Involved? □ Yes □ 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 TRISTAR Inc. (Not CareSys), AT 1-855-495-1554 AND REPORT THE INJURY OR ILLNESS, and CALL TAYANNA CROWDER AT (618) 650-2190.*** |
| **Describe Nature And Scope** Of Personal Injury, If Any \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Was Medical Care Sought**? □ No □ 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) |