

INJURY REPORT FORM FOR STUDENTS OR PUBLIC

Date Reported: _____ Reported By: _____
 Department: _____ Campus Address: _____
 Campus Phone: _____ E-mail Address: _____

INJURED PERSON

Name: _____ Age: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Student Public
 Reason on campus: _____

INJURY

Was the person taken to a doctor or hospital? Yes No
 If yes, where? _____

ACCIDENT

Date: _____ Time: _____
 Campus: _____ Location: _____
 Description of the Accident: _____

 Cause of the Accident: _____

 Were Police or Emergency Services contacted? Yes No

Name of Witness(es)	Phone	Address	City	State	Zip

Signature		Date	
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PLEASE MAIL OR FAX COMPLETED FORM TO RISK MANAGEMENT