UND INCIDENT REPORTING FORM FOR A PERSON

Must submit completed form to the Office of Safety within 24 hours (one business day) of incident.

Please fill in ALL fields. If a field doesn't apply, please type in 'N/A'.

Person completing form: Last name: _____ First name: _____ Phone: _____

Date incident occurred: _____ Time: _____ ☐ AM ☐ PM Time Shift Began: _____ ☐ AM ☐ PM

Date employer was notified: _____ Who was notified? _____

PART A: AFFECTED INDIVIDUAL

Injured/Involved person: Last name: _____ First name: _____

Local address (include city, state, zip code): _____

Sex: ☐ Female ☐ Male Phone: _____ Email: _____

Marital Status: _____ Name of Parent/Guardian (if under 18): _____

UND Status: ☐ Employee ☐ Student Employee ☐ Student (Non-employee) ☐ Visitor/Patient/Other

- **If an employee or student employee, complete the following if injured at work:**

Employing Department: _____ Supervisor: _____

Supervisor Email: _____ Supervisor Phone: _____ Hire Date: _____

Job Title of Injured Person: _____ ☐ Full-Time ☐ Part-Time

Was the injury/illness work related? ☐ Yes ☐ No If yes, contact Office of Safety to file a claim.

PART B: INJURY/ILLNESS

Type of Incident: ☐ Near Miss ☐ Slight Injury/Illness (not requiring professional medical attention)
☐ Injury/Illness (requiring professional medical attention – submit Physician's Report)

Address (Building/Room) of incident: _____

Was the incident: ☐ Inside ☐ Outside If outside: ☐ Clear ☐ Raining ☐ Snowing ☐ Other: _____

Body part(s) injured (be specific): _____ If Sharps related, complete Sharps Injury Form.

Brief description of incident: _____

_____

Law Enforcement or First Responders called? ☐ Yes ☐ No If yes, did they transport injured? ☐ Yes ☐ No

Last date worked PRIOR to incident: _____ Time lost from work (days, hours): _____

Witness(es) to incident: Name(s): _____ Phone: _____

PART C: MEDICAL ATTENTION RECEIVED (Must be with a Designated Medical Provider (DMP))

NOTE: *Employees who seek medical attention need to contact the Office of Safety as soon as possible to provide additional information not contained in this document. This information is required to process any related claims.*

Medical Facility: _____ City/State: _____

Physician/Provider: _____ Date of Treatment: _____

Description of medical attention received: _____

The above information in this report is accurate based on my knowledge of the incident.

Signature: _____ Date: _____

Supervisor's signature: _____ Date: _____

Supervisor's printed name: _____

Save and email this form to und.safety@email.und.edu and your supervisor for review and signature.