UND INCIDENT REPORTING FORM FOR PERSONAL INJURY

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))

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.