REPORT OF INCIDENT OR ACCIDENT

(Non-University employee)

CALIFORNIA STATE UNIVERSITY, Fresno

ATTENTION: This form contains information relating to an injured individual's health and must be used in a manner that protects the confidentiality of the injured to the extent possible while the information is being used for safety and health purposes. This form must be completed within 24 hours of receiving information of a university-related injury or illness and emailed to ehsrm@mail.fresnostate.edu or faxed to 559-278-1153.

IMPORTANT: Please go to http://www.csufresno.edu/adminserv/ehsrm/about/forms/az.html *Accident or Incident Report (non-University employee)*, to ensure that you are using the most current version of this form.

SECTION 1: UNIVERSITY RELATIONSHIP (SELECT ONLY ONE)

☐Student ☐Volunteer ☐Visitor ☐Contractor Fresno State Police Report Made? ☐YES ☐NO

SECTION 2: INCIDENT TYPE (SELECT ONLY ONE)

☐Injury ☐Illness ☐Other (Vehicle, Near Miss, Dangerous Condition, Exposure Incident) _____

SECTION 3: INVOLVED PERSON'S INFORMATION

First Name: _____ Last Name: _____ M.I.: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Work Ph: _____ Cell Ph: _____ Email: _____

☐ Male ☐ Female Under 18? ☐YES ☐NO

SECTION 4: INCIDENT DETAILS

Date of Injury/Illness: _____ Time: AM/PM _____ Location: _____

Reminder: Please fill out 2nd page/back page regarding description of incident.

Name(s) of Witnesses:

1. NAME *(Last, First, M.I.)*	ADDRESS *(Street, City, State, Zip)*	CONTACT TELEPHONE
2. NAME *(Last, First, M.I.)*	ADDRESS *(Street, City, State, Zip)*	CONTACT TELEPHONE
3. NAME *(Last, First, M.I.)*	ADDRESS *(Street, City, State, Zip)*	CONTACT TELEPHONE

If the incident resulted in an injury or illness, answer the following questions.

a) Did the individual receive medical treatment in an emergency room? ☐YES ☐NO

b) Was the individual hospitalized overnight as an in-patient? ☐YES ☐NO

c) Did the individual receive medical treatment beyond basic first aid? ☐YES ☐NO

SECTION 5: HOSPITAL/CLINIC INFORMATION

Name of Facility: _____

Address of Facility: _____

Treating Physician: _____ Phone Number: _____

SECTION 6: REPORTING INDIVIDUAL

Reporting Employee's Name*(Print or Type)* _____ Telephone _____

Reporting Employee's Department/Office _____ Email _____Date _____

Please proceed to next page to continue completing form.

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DESCRIBE THE INCIDENT (STATE ONLY THE FACTS). Attach additional sheet of paper if necessary.

What was the person doing just prior to, and at the time of the incident? What objects/conditions contributed to the incident?