ACCIDENT/INJURY REPORT
FACILITIES MANAGEMENT/SAFETY

701.671.2211 | Email: ndscs.safety@ndscs.edu

Complete and submit form within 24 hours of the incident. For guidance through the incident, see the Accident/Injury Reporting Responsibilities.

Date Submitted: _____ Time: _____ ☐am ☐pm

PERSON INVOLVED INFORMATION:

Last Name: _____ First Name:_____ Sex: ☐M ☐F

Date of Birth: _____ Marital Status: _____ SS# (last 4-digits):_____

☐Faculty ☐Staff ☐Student ☐Visitor NDSCS ID:_____ Employment Start Date: _____

Home Address:_____ City, State, Zip: _____

Phone: _____ Work Phone: _____ Email:_____

Job Title:_____ Supervisor: _____

INCIDENT INFORMATION:

Incident Date:_____ Incident Time:_____ ☐am ☐pm

Campus Location:_____ Building:_____ Area/Room: _____

Off-Site Location: _____

Incident Type	Cause		Result of Event	
☐Medical	☐Machinery	☐Motor Vehicle	☐Abrasion	☐Laceration	☐Amputation
☐Trama	☐Electrical	☐Fall	☐Sprain	☐Fracture	☐Burn
☐Safety	☐Chemical	☐Slip/Trip	☐Vision Loss	☐Heat Exhaustion	☐Heat Stroke
☐Fire	☐Tool	☐Vehicle	☐Cold Exposure	☐Electrical Shock	
☐Other:	☐Other:		☐Other:		

INVOLVED BODY PART:

☐Head ☐Face ☐Neck ☐Chest ☐Abdomen ☐Back

Right: ☐Arm ☐Wrist ☐Hand ☐Leg ☐Knee ☐Ankle ☐Foot ☐Fingers _____

Left: ☐Arm ☐Wrist ☐Hand ☐Leg ☐Knee ☐Ankle ☐Foot ☐Fingers _____

MEDICAL ACTIONS:

First Aid (only)☐ | Transported to: ☐Clinic ☐Hospital | By: ☐EMS ☐Car | Admitted: ☐Yes ☐No

See Physician: ☐Yes ☐No Physician Name: _____ Clinic/Hospital: _____

AFTER ACTION REVIEW:

What happened: What was supposed to happen:

Immediate actions: Corrective Actions:

ADDITIONAL COMMENTS:

SUBMITTER INFORMATION:

Name: _____ Phone: _____ Email:_____

Signature: _____