INCIDENT REPORT
FACILITIES MANAGEMENT/SAFETY

701.671.2352 | 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.

*****IN EMERGENCIES DIAL 911*****

TYPE OF INCIDENT:

☐Near Miss ☐Slight Injury/Illness (not requiring professional medical attention)

☐Injury/Illness (requiring professional medical attention) – **Complete Part C, Give *Report of Workability* to Safey ASAP * Medical attention MUST be provided by a *Designated Medical Provider***

PART A: 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: _____

PART B: INCIDENT INFORMATION:

Incident Date: _____ Incident Time: _____ ☐am ☐pm
Campus Location: _____ Building: _____ Area/Room: _____
☐Inside ☐Outside If Outside: ☐Clear ☐Raining ☐Snow ☐Other_____
Off-Site Location: _____
Last Day Worked Prior to Injury: _____ Date Supervisor Notified: _____
DESCRIPTION/CAUSE OF INCIDENT:

_____
_____
_____

BODY PART AND TYPE OF INJURY (BE SPECIFIC, INCLUDE LEFT, RIGHT, BIG TOE,ELBOW, CUT, BURN):

_____
_____
_____

Witnesses or person notified: _____

PART C: MEDICAL ACTION INFORMATION:

Treating Medical Facility: _____ Date of Treatment: _____
Physician: _____
Description of Treatment: _____

**After initial treatment, submit this form and Safety will reach out for additional information, including Social Security Information and Birth date for claim filing and management

ADDITIONAL COMMENTS:

Be sure to participate in all Root Cause Analysis and Claims management follow-up requirements.

SUBMITTER INFORMATION:

Name: _____ Phone: _____ Date: _____
Signature/Digital Signature Submission: _____