Slippery Rock University℠

Accident/Incident Report Form
(For Use by Slippery Rock Employees, Students, & Visitors)

Instructions for Report Completion: Slippery Rock University employees, students and visitors are to complete this Accident/Incident form as soon as possible, preferable within twenty-four (24) hours of the accident/incident and send to the Department of Facilities, Planning & Environmental Safety, Slippery Rock University, Maintenance Center Building, 100 Buildings & Grounds Road, Slippery Rock, PA 16057. Phone: 724-738-2465 FAX 724-738-2540. PLEASE PRINT ALL INFORMATION.

IMPORTANT: All SRU Employees must sign the form and also obtain their supervisor's signature on this report form. An employee's social security number is required to process workers' compensation claim on their behalf.

INDIVIDUAL IDENTIFICATION

1. Date/Time of Accident/Incident _____
2. Full Name _____
3. Street Address _____
4. City/State/Zip Code _____
5. Home Phone Number _____
6. Cell Phone Number _____
7. Work Phone Number _____
8. Email Address _____
9. Date of Birth _____
10. Job Title _____
11. ☐ Male ☐ Female (select one)

ACCIDENT/INCIDENT INFORMATION

12. Location of Accident/Incident (Indoors provide building, room number or area, such as stairs, hallway, etc… Outdoors describe area:

_____
_____
_____
_____

13. Were you performing regular job duties at the time of the accident/incident?

☐ Yes ☐ No ☐ Not Applicable

14. Did injury occur? ☐ Yes ☐ No

15. Did property loss or damage occur? ☐ Yes ☐ No

16. Please describe details of the accident/incident:

_____
_____
_____
_____
_____

17. If property damage occurred, please describe as best as possible:

_____
_____
_____
_____

18. Were there any witnesses? ☐ Yes ☐ No

Name and phone number of any witnesses (if applicable):

_____
_____
_____

19. If injury occurred, please indicate location: ☐ Left ☐ Right

☐ Hand ☐ Finger ☐ Arm ☐ Elbow ☐ Wrist
☐ Shoulder ☐ Neck ☐ Face ☐ Teeth ☐ Eye
☐ Foot ☐ Toe ☐ Leg ☐ Knee ☐ Ankle
☐ Head ☐ Ear ☐ Nose ☐ Throat ☐ Lungs
☐ Abdomen ☐ Groin ☐ Lwr Back ☐ MidBack ☐ Upper Back

20. Describe injury (Cut, sprain, burn, exposure, etc.)

_____
_____
_____
_____

21. Did the accident involve a slip, trip or fall? ☐ Yes ☐ No

22. Did the accident involve lifting? ☐ Yes ☐ No

23. Is this type of work performed regularly? ☐ Yes ☐ No

24. If injury occurred, did it appear immediately? ☐ Yes ☐ No

INFORMATION REGARDING MEDICAL TREATMENT/MISSED WORK TIME

25. Were you evaluated/treated by a medical provider/physician?

☐ Yes ☐ No

If yes, physician's name and phone number:

_____
_____

Date(s) of treatment: _____

26. Did you go to a hospital? ☐ Yes ☐ No

If yes, Date & Hospital name:

_____

_____

27. Did you miss work? ☐ Yes ☐ No

If yes, work days/time missed _____

Last day worked _____

Return to work date _____

28. If injury occurred, did it aggravate a previous injury?

Signature/Authorization

I certify that the information set forth is true and correct to the best of my knowledge.

Name _____ Date_____

(Print)

Signature_____

SRU Employees Only:

Employee's Department_____

Supervisor Name_____ Campus Extension_____

Supervisor Instructions: Please review circumstances of accident/injury with employee and include any actions if applicable that have been/will be taken to prevent future occurrence:

Supervisor's Signature_____

EHS Use Only

Accident/Injury Review Performed _____
Date

Injury obtained in the normal course of the employee's job duties?
☐ Yes ☐ No ☐ Not Applicable

Accident/Injury Reviewed by_____
EHS personnel

Workers' Compensation Claim

Worker's Compensation Claim Filed on _____(Date)

Claim #_____

Claim filed by_____
EHS personnel

Revised March 22, 2023