

<i>Injury - Incident Report</i> For completion by Injured Individual		Allegheny College		
Incident Information		Relationship to the College Mark all that apply <input checked="" type="checkbox"/>		
Date	Time	<input type="checkbox"/> Employee <input type="checkbox"/> Student Worker <input type="checkbox"/> Other	<input type="checkbox"/> Faculty <input type="checkbox"/> Administrator	
Location				<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Casual
Date of Hire	Start of Shift			
Department	Supervisor			
Employee's Information		Employer Notified (Date & Time):		
Name (Last, First, MI, Suffix):		Supervisor Notified (Date & Time):		
Residence:	<input type="checkbox"/> Male <input type="checkbox"/> Female	DOB	Social Security Number:	
Street	Home Telephone		Home e-mail	
City	Work Telephone		Work e-mail	
State	Zip code	Cell / Mobile phone	Work Fax	
If not employed by _____, where?				
Secondary Employment <input type="checkbox"/> Yes <input type="checkbox"/> No		Where?		
Injury Information <input type="checkbox"/> N/A				
Nature of Injury Mark all that apply <input checked="" type="checkbox"/>		Body Part(s) Injured Mark all that apply <input checked="" type="checkbox"/>		
<input type="checkbox"/> Abrasion <input type="checkbox"/> Amputation <input type="checkbox"/> Bruise <input type="checkbox"/> Burn (chemical) <input type="checkbox"/> Burn (thermal) <input type="checkbox"/> Concussion <input type="checkbox"/> Carpal Tunnel	<input type="checkbox"/> Contusion <input type="checkbox"/> Cut-laceration <input type="checkbox"/> Death / Fatality <input type="checkbox"/> Dermatitis <input type="checkbox"/> Dislocation <input type="checkbox"/> Electrical shock <input type="checkbox"/> Fracture	<input type="checkbox"/> Hernia <input type="checkbox"/> Infection <input type="checkbox"/> Needle stick <input type="checkbox"/> Other <input type="checkbox"/> Puncture wound <input type="checkbox"/> Sprain / Strain	<input type="checkbox"/> Abdomen <input type="checkbox"/> Ankle <input type="checkbox"/> Arm, upper <input type="checkbox"/> Back <input type="checkbox"/> Chest <input type="checkbox"/> Elbow	
		<input type="checkbox"/> Finger <input type="checkbox"/> Foot <input type="checkbox"/> Forearm <input type="checkbox"/> Groin <input type="checkbox"/> Hand <input type="checkbox"/> Head	<input type="checkbox"/> Hip <input type="checkbox"/> Knee <input type="checkbox"/> Leg <input type="checkbox"/> Multiple <input type="checkbox"/> Neck <input type="checkbox"/> Other	
			<input type="checkbox"/> Shoulder <input type="checkbox"/> Thigh <input type="checkbox"/> Thumb <input type="checkbox"/> Toe(s) <input type="checkbox"/> Wrist <input type="checkbox"/> Eye injury	
Treatment Mark all that apply <input checked="" type="checkbox"/>				
<input type="checkbox"/> N/A Not needed <input type="checkbox"/> Medical Treatment Requested <input type="checkbox"/> Recommended by supervisor <input type="checkbox"/> Medical Treatment Refused	<input type="checkbox"/> No Medical Care on scene <input type="checkbox"/> Self Care on scene <input type="checkbox"/> First Aid provided on scene <input type="checkbox"/> Non-Emergency care <input type="checkbox"/> Emergency Medical care	<input type="checkbox"/> Treated on Scene by Public Safety <input type="checkbox"/> Treated on Scene by EMS <input type="checkbox"/> Transported by Self <input type="checkbox"/> Transported by Public Safety <input type="checkbox"/> Transported by EMS	<input type="checkbox"/> Clinic / Hospital <input type="checkbox"/> College Health Center <input type="checkbox"/> Panel Physician <input type="checkbox"/> Subject's Physician <input type="checkbox"/> Emergency Department	
If transported to clinic, hospital or physician, where? <input type="checkbox"/> Other:				
Safety Information Was Personal Protection Equipment (PPE) required? <input type="checkbox"/> Yes <input type="checkbox"/> No Was PPE worn? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not?				
PPE Available? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not? PPE Type:				
Describe what you were doing at the time of the incident:		Describe the conditions in area: (Clothing worn; weather, lighting, surfaces...)		
Description of incident (Attach additional pages if needed)				
Recommendation on how to prevent this incident from recurring:				
If injured, what is the specific nature of the injury?				
Describe any equipment, machinery, object or substance that may have directly harmed the subject. Was the employee trained to utilize the equipment? If no, why not?				

Witness(es) to incident <input type="checkbox"/> None (Attach additional pages if needed)		
Name	Address	Contact (Telephone, e-mail)
DPS Notified <input type="checkbox"/> Yes <input type="checkbox"/> No	Person completing Report Name & Title, Contact Telephone Number:	Date Completed

Forward Report to: