

**REPORT OF INCIDENT OR ACCIDENT**  
CALIFORNIA STATE UNIVERSITY, SACRAMENTO

H.R. use only - OSHA Log Case No.

**ATTENTION:** This form contains information relating to an injured employee'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. Reference: 8 CCR § 14300.29 (b)(6)-(10). This form must be completed within 24 hours of receiving information of an occupational or other university-related injury or illness **and faxed to Human Resources Disability Leaves Office at (916) 278-3411.**

**IMPORTANT:** Please go to [www.csus.edu/hr/forms.htm](http://www.csus.edu/hr/forms.htm) Report an Incident or Accident, to ensure that you are using the most current version of this form.

**SECTION 1: UNIVERSITY RELATIONSHIP (SELECT ONLY ONE)**

Faculty (dept): \_\_\_\_\_  Staff (dept): \_\_\_\_\_  Student Emp.  Student Asst.  Student  
 Auxilliary  Contractor 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/INJURED'S INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ M.I.: \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Bargaining Unit: \_\_\_\_\_  
 Male  Female Date of Birth: \_\_\_\_\_ Date Hired Or N/A \_\_\_\_\_

**SECTION 4: INCIDENT DETAILS**

**Note:** If an accident occurred while driving on university business, you must also complete the Vehicle Accident Report form STD 270.

Date of Injury/Illness: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM \_\_\_\_\_ Location: \_\_\_\_\_

**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?

Name(s) of Injured Persons & Witnesses: \_\_\_\_\_

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

- If this was a Sac State employee injury or illness, at what time did the employee begin their shift?: \_\_\_\_\_  a.m.  p.m.  N/A
- 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
  - d) Did the individual immediately return to work?  YES  NO
  - e) Did the individual receive a modified work schedule due to the incident?  YES  NO
  - f) Did the injury or illness result in death? Date of Death: \_\_\_\_\_  YES  NO
  - g) Date notified supervisor that injury occurred. \_\_\_\_\_

**SECTION 5: HOSPITAL/CLINIC INFORMATION**

Name of Clinic: \_\_\_\_\_  
Address of Clinic: \_\_\_\_\_  
Treating Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## REPORT OF INCIDENT OR ACCIDENT

CALIFORNIA STATE UNIVERSITY, SACRAMENTO

### SECTION 6: INJURY/ILLNESS CATEGORIZATION

#### Section 6A: Part of Body Injured

L	R		L	R		L	R		L	R	
<input type="checkbox"/>	<input type="checkbox"/>	Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	Eye	<input type="checkbox"/>	<input type="checkbox"/>	Head	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder
<input type="checkbox"/>	<input type="checkbox"/>	Ankle	<input type="checkbox"/>	<input type="checkbox"/>	Face	<input type="checkbox"/>	<input type="checkbox"/>	Internal	<input type="checkbox"/>	<input type="checkbox"/>	Teeth
<input type="checkbox"/>	<input type="checkbox"/>	Arm-Lower	<input type="checkbox"/>	<input type="checkbox"/>	Fingers	<input type="checkbox"/>	<input type="checkbox"/>	Knee	<input type="checkbox"/>	<input type="checkbox"/>	Thigh
<input type="checkbox"/>	<input type="checkbox"/>	Arm-Upper	<input type="checkbox"/>	<input type="checkbox"/>	Foot	<input type="checkbox"/>	<input type="checkbox"/>	Leg-Lower	<input type="checkbox"/>	<input type="checkbox"/>	Throat
<input type="checkbox"/>	<input type="checkbox"/>	Back-Lower	<input type="checkbox"/>	<input type="checkbox"/>	Forearm	<input type="checkbox"/>	<input type="checkbox"/>	Leg-Upper	<input type="checkbox"/>	<input type="checkbox"/>	Toes
<input type="checkbox"/>	<input type="checkbox"/>	Back-Upper	<input type="checkbox"/>	<input type="checkbox"/>	Genitals	<input type="checkbox"/>	<input type="checkbox"/>	Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Torso
<input type="checkbox"/>	<input type="checkbox"/>	Ear	<input type="checkbox"/>	<input type="checkbox"/>	Groin	<input type="checkbox"/>	<input type="checkbox"/>	Neck	<input type="checkbox"/>	<input type="checkbox"/>	Wrist
<input type="checkbox"/>	<input type="checkbox"/>	Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Hand	<input type="checkbox"/>	<input type="checkbox"/>	Nose	<input type="checkbox"/>	<input type="checkbox"/>	Other:

#### Section 6B: Nature of Injury

<input type="checkbox"/> Abrasion	<input type="checkbox"/> Burn - Thermal	<input type="checkbox"/> Fracture - Break	<input type="checkbox"/> Repetitive Motion
<input type="checkbox"/> Amputation	<input type="checkbox"/> Burn - Electrical	<input type="checkbox"/> Hearing	<input type="checkbox"/> Splinter
<input type="checkbox"/> Bite/Sting	<input type="checkbox"/> Crushed	<input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Sprain/Strain
<input type="checkbox"/> Blister	<input type="checkbox"/> Cut/Laceration	<input type="checkbox"/> Numbness	<input type="checkbox"/> Swelling
<input type="checkbox"/> Bruise/Contusion	<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Pain	<input type="checkbox"/> Other (explain below):
<input type="checkbox"/> Burn - Chemical	<input type="checkbox"/> Dislocation	<input type="checkbox"/> Puncture	

***Based upon my personal knowledge and/or information reasonably available to me, the above is true and correct.***

### SECTION 7: REPORT PREPARER'S INFORMATION

Print Name: \_\_\_\_\_ Title: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Sign: \_\_\_\_\_ Prep. Date: \_\_\_\_\_

### SECTION 8: ASSESSMENT AND CORRECTIVE ACTIONS

**For Sac State employee injuries, Section 8 is to be completed by the employee's MPP or HEERA designated supervisor.**

#### Potential Cause of Incident

Condition(s)	Action(s)
<input type="checkbox"/> Exposed electrical wiring	<input type="checkbox"/> Bypassed safety device
<input type="checkbox"/> Defective tools or equipment	<input type="checkbox"/> Equipment, failure to secure
<input type="checkbox"/> Hazardous arrangement	<input type="checkbox"/> Equipment, improper positioning
<input type="checkbox"/> Fall hazard	<input type="checkbox"/> Equipment, used inappropriate equipment
<input type="checkbox"/> Insufficient illumination	<input type="checkbox"/> Equipment, use of defective
<input type="checkbox"/> Improper PPE	<input type="checkbox"/> Failure to lockout or tagout
<input type="checkbox"/> Misplaced object	<input type="checkbox"/> Failure to use PPE
<input type="checkbox"/> Object in motion	<input type="checkbox"/> Horse-play
<input type="checkbox"/> Tripping or slipping hazard (slip, trip, or fall)	<input type="checkbox"/> Improper lifting techniques
<input type="checkbox"/> Hazardous atmosphere	<input type="checkbox"/> Operating equipment without training
<input type="checkbox"/> Other (explain):	<input type="checkbox"/> Other (explain):
<input type="checkbox"/> None	<input type="checkbox"/> None

What corrective actions have been taken to ensure that this incident (or hazardous condition) will not occur again?

\_\_\_\_\_  
Reviewer's Name and Title (Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date