TARLETON STATE UNIVERSITY
Report of Accident/Illness

To Be Completed IMMEDIATELY by the Injured Person

Name: ____________________________ **UIN:** ____________________________

Address: ____________________________ **City** ______________ **State** ______ **Zip** ________

Phone Number: ( ) ____________________________ **DOB:** ____________________________

Ethnicity (check one): _____White _____Black _____Hispanic _____Native American _____Asian _____Other

Marital Status (check one): _____Single _____Separated _____Widowed _____Married _____Divorced

If married, spouses name: ____________________________ **# of Dependents:** ________________

Classification (check one): _____Staff _____Faculty _____Student employee _____Student _____Visitor

Job Title: ____________________________ **Department:** ____________________________

Supervisor: ______________________ **He/She Notified:** ___YES ___NO **If yes date/time:** __________

Date of Injury: ____________________________ **Time of Injury:** ____________________________

Facility/Location Where Injury Occurred: ____________________________

Machine/Tool/Thing/Person Causing Injury: ____________________________

Describe in Detail How Accident Occurred and What You Were Doing When Injured:

____

____

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____

What is the nature of the injury (ie: sprain, fracture, etc.): ____________________________

What part(s) of the body was injured: (please check one)

Head__	Rt. Arm__	Lt. Arm__	Rt. Leg__	Lt. Leg__	Neck__
Face__	Rt. Elbow__	Lt. Elbow__	Rt. Knee__	Lt. Knee__	Chest__
Eye__	Rt. Wrist__	Lt. Wrist__	Rt. Ankle__	Lt. Ankle__	Lower Back__
Ear__	Rt. Hand__	Lt. Hand__	Rt. Foot__	Lt. Foot__	Upper Back__

Finger (Specify which hand and finger below)___ **Toe** (Specify which foot and toe below)___ **Nose__** **Stomach__**

Other: ____________________________

Describe in Detail the Injury: ____________________________

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Witnesses: ____________________________ **Did You Go to the Hospital:** __Yes __No

If Yes, Where: ____________________________

Employee Signature: ____________________________ **Date:** ____________________

TARLETON STATE UNIVERSITY
Supervisor & Department Head/Director Report of Accident/Illness

To be completed *immediately* following an Accident *(If employed by the University.)*

Employee Name: ____

Date of Injury: ____________________ **Date and Time You Were Notified:** ____________________

What is the nature of the injury (ie: sprain, fracture, etc.)**:** ______________________________

Cause of the Injury: ____

Physical Location of Where the Injury Occurred: ______________________________

Was a Safety Appliance in Use? ____Yes ____No ____Unknown

Was the employee trained on how to prevent the injury? ____Yes ____No

Is there training available to prevent this injury? ____Yes ____No

If yes, what kind: ____

Did the unit have a safety rule, regulation, or standard that, if complied with, would have prevented the occurrence? ___Yes ___No ___N/A

Was the rule, regulation, or standard violated? ___Yes ___No ____N/A

Do you concur with the *Initial Injury Report Form*? ____Yes ____No

If no, what action have you taken?

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____

How can an injury like this be prevented in the future:

____

____

____

Did employee seek medical attention: ____Yes ____No

If so, Where Was the Employee Treated: ______________________________

First Day Unable to Work: *(if applicable)***:** ______________________________

Supervisor Signature (please print)**:** ______________________________ **Date:** ____________

Department Head/Director Signature (please print)**:** ______________________ **Date:** ____________

RETURN THIS FORM TO:
Tarleton Department of Risk Management & Safety
Box T-0830 or fax (254) 968-9658

For additional information call:
(254) 968-9898

SEND COPY OF FORM TO:
Department of Employee Services
Box T-0510 or fax (254) 968-9590