NON-EMPLOYEE ACCIDENT/INCIDENT REPORT FORM

These forms should be filled out immediately and routed to Emergency and Risk Management, Bldg 3.

Date of Injury/Incident ______ / ______ / ______

Time of Injury/Incident _____ : ______ am/pm

Name ___________________________________________

Phone No. ________ - ________ - ______________

Address _________________________________________   ______________________   ______   ___________

Street or P.O. Box  City   State   Zip

D.O.B. ______ / ______ / ________   Sex   ☐ M   ☐ F

☐ Student   ☐ Visitor

Place of Injury/Incident:   Bldg._______ Rm. ________

Engaged in Class Activity?  ☐ Y  ☐ N

Specify class/section/instructor

Other ___________________________________________

Witnesses

Name ___________________________________________

Address _________________________________________

Name ___________________________________________

Address _________________________________________

Description of Accident/Incident:

____________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

Degree of Injury:

☐ Death   ☐ Impairment   ☐ Temporary Disability   ☐ Nondisabling

Dispositions of Accident:

Taken to Health Clinic?  ☐ Y  ☐ N  By Whom? ___________________________   When? ________________

Transported?  ☐ Y  ☐ N  By Whom? ___________________________   Where? ________________

First Aid administered?  ☐ Y  ☐ N  By Whom? ___________________________   When? ________________

Treatment applied: ____________________________________________

Advised to see a Physician?  ☐ Y  ☐ N

Was blood present?  ☐ Y  ☐ N  Was there unsafe contact?  ☐ Y  ☐ N  If yes, get help ASAP.

Basic source/cause of Injury/Incident:   ☐ Unsafe conditions   ☐ Training Needed  ☐ Safety rules not followed

Other ___________________________________________

Recommendations to prevent reoccurrence ______________________________________

Health Clinic Comments _____________________________________________________

____________________________________________________________________________

_________________________________________________________________________________________________

_________________________________________________________________________________________________

This for may be downloaded at:

https://www.lanecc.edu/copps/documents/accident-reporting

Signature of person injured

Signature of person injured

Staff member in charge at time of accident (If applicable)

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