MIAMI UNIVERSITY

Environmental Health & Safety Offices
164 Cole Service Building
(513) 529-2829

Incident Report for Non-Occupational Accident/Injury

Email report to: injuryreport@listserv.miamioh.edu

Name: _____ **Daytime Phone No.**: _____

Street: _____ **City**_____ **State** ____ **Zip** _____

Sex: Male ☐ Female ☐ **Age**: _____ **Employee** ☐ **Student** ☐ **Visitor** ☐

Location of Incident: _____

Time & Date of Incident: _____

Witness Name:_____ **Daytime Phone No**:_____

If applicable: Course No: _____ Course Instructor: _____

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1. **Injured party's account of accident: (explain in detail how the accident occurred) injured party must sign below to attest accuracy of event***

_____
_____
_____
_____
_____

2. **Activity being done at the time of the injury:**

_____
_____
_____
_____
_____

3. **Specific part of body injured**

_____
_____
_____

First Aid Rendered (Check all that apply)

☐ Injured party's self-care*
☐ Recommended Miami Police be called
☐ Injured party refused Miami Police recommendation*
☐ Called Miami Police
☐ Left area, no information
☐ Referred to health service
☐ Miami Police to hospital
☐ Lifesquad to hospital

Notified Progam Staff (name below)
_____

Notified Director (name below)
_____

Describe Care Given
_____
_____
_____

Nature of Suspected Injury or Illness:

Injury	**Illness**
☐ Bruise	☐ Allergic Reaction
☐ Concussion	☐ Hyperventilation
☐ Cut	☐ Diabetic Reaction
☐ Closed Wound	☐ Fever
☐ Dental	☐ Faint
☐ Spinal Injury	☐ Gastrointestinal
☐ Sprain/Strain	☐ Heart (angina, arrest)
☐ Dislocation	☐ Heat Reaction
☐ Fracture	☐ Respiratory
☐ Puncture	☐ Seizure
☐ Other	☐ Other

Follow-up information

Degree of Treatment: ☐ No Treatment Required ☐ First Aid Only ☐ Medical Treatment Required

Treatment Provided By: _____

_____ _____
Injured Party's Signature if **STAFF PROVIDED CARE** Date Form Completed
(parent or guardian if victim is under 18)

_____ _____
Injured Party's Signature **REFUSAL OF CARE** Date Form Completed
(parent or guardian if victim is under 18)

Scan and email report to: injuryreport@listserv.miamioh.edu

To be completed by the Department of Environmental Health & Safety personnel ONLY!

_____ _____ _____
Case Number Investigated by Date of Investigation

Was further investigation necessary? Yes __ No __ (If yes, use a separte form for details)

Witness's Information

Name _____ Telephone _____
Address _____ City _____ State _____ Zip _____

Witness's Account of Action: (explain in detail the events, actions, and conditions that may have contributed to the injury)

_____
_____
_____
_____
_____

Witness's Signature: _____ Position (if staff member) _____ Date: _____

Report Filer's Information

Name _____ Telephone _____
Address _____ City _____ State _____ Zip _____

Report Filer's Account of Action: (explain in detail the events, actions, and conditions that may have contributed to the injury)

_____
_____
_____
_____
_____

Report Filer Signature: _____ Position (if staff member) _____ Date: _____

Office Action

Follow-up Comments:

Date Call / Contact made: _____ Your Name: _____

Comments:

_____
_____
_____
_____

Reviewed by: _____

Position: _____ Date: _____

Copies -

This form has been copied to: (list program area and supervisor) -

_____
_____
_____
_____
_____