

## REPORT OF INCIDENT OR ACCIDENT

(Non-University employee)

CALIFORNIA STATE UNIVERSITY, Fresno

ATTENTION: This form contains information relating to an injured individual'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. This form must be completed within 24 hours of receiving information of a university-related injury or illness and emailed to [ehsrm@mail.fresnostate.edu](mailto:ehsrm@mail.fresnostate.edu).

IMPORTANT: Please go to <http://www.csufresno.edu/adminserv/ehsrm/about/forms/az.html> Accident or Incident Report (non-University employee), to ensure that you are using the most current version of this form.

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

☐ Student ☐ Volunteer ☐ Visitor ☐ Contractor

Fresno State 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 PERSON'S INFORMATION

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ M.I.: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Work Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_ Email: \_\_\_\_\_

☐ Male ☐ Female Under 18? ☐ YES ☐ NO

### SECTION 4: INCIDENT DETAILS

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

**Reminder:** Please fill out 2<sup>nd</sup> page/back page regarding description of incident.

Name(s) of Witnesses:

|                             |                                    |                   |
|-----------------------------|------------------------------------|-------------------|
| 1. NAME (Last, First, M.I.) | ADDRESS (Street, City, State, Zip) | CONTACT TELEPHONE |
| 2. NAME (Last, First, M.I.) | ADDRESS (Street, City, State, Zip) | CONTACT TELEPHONE |
| 3. NAME (Last, First, M.I.) | ADDRESS (Street, City, State, Zip) | CONTACT TELEPHONE |

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

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

### SECTION 5: HOSPITAL/CLINIC INFORMATION

Name of Facility: \_\_\_\_\_

Address of Facility: \_\_\_\_\_

Treating Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

### SECTION 6: REPORTING INDIVIDUAL

Reporting Employee's Name(Print or Type) \_\_\_\_\_ Telephone \_\_\_\_\_

Reporting Employee's Department/Office \_\_\_\_\_ Email \_\_\_\_\_ Date \_\_\_\_\_

Please proceed to next page to continue completing form.

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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?