

**STUDENT OR VISITOR
INJURY/ILLNESS
REPORT**

Case Number

PART I – TO BE COMPLETED BY INJURED/ILL OR REPORTING PERSON

Name		Campuswide ID	Date of Birth	Extension
Street		City	State	Zip
Home Phone Number	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Department or Sponsoring Organization	<input type="checkbox"/> Student <input type="checkbox"/> Student on Work Study	<input type="checkbox"/> Student Assistant <input type="checkbox"/> Visitor

Activity During Accident / Illness
 Attending Class, Lab, etc. Research Field Trip Club or Organization Free Time Other _____
 Sports Activity P.E. Class Intramurals Intercollegiate Unsupervised
 Specific Sport _____ Name of Coach or Witness Present _____
 Medical Treatment Provided: Yes No Returned to Activity: Yes No

Describe the injury/illness, including what, where, why, how the injury/illness occurred:
 Date: _____ Time: _____ Location: _____

Signature (If able)	Date	Report Completed By	Date	Phone Number
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PART II – TO BE COMPLETED INSTRUCTOR, DEPARTMENT CHAIR OR AUTHORIZED REPRESENTATIVE OF THE ORGANIZATION CONDUCTING THE ACTIVITY

Date of Injury / Illness / Death	Date of knowledge of Injury	Time of Injury / illness Hour _____ <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
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Describe the injury/illness, including what, where, why, how the injury/illness occurred:

What has been done to correct any condition that might have contributed to the injury / illness?

What do you recommend for correction?

Part of Body (check) Indicate Right of Left when Applicable 1. <input type="checkbox"/> Head 10. <input type="checkbox"/> Wrist 19. <input type="checkbox"/> Neck 2. <input type="checkbox"/> Face 11. <input type="checkbox"/> Hand 20. <input type="checkbox"/> Shoulder 3. <input type="checkbox"/> Eye 12. <input type="checkbox"/> Finger 21. <input type="checkbox"/> Groin 4. <input type="checkbox"/> Ear 13. <input type="checkbox"/> Knee 22. <input type="checkbox"/> No Injury 5. <input type="checkbox"/> Mouth 14. <input type="checkbox"/> Leg 23. <input type="checkbox"/> Other _____ 6. <input type="checkbox"/> Heart 15. <input type="checkbox"/> Ankle 7. <input type="checkbox"/> Back 16. <input type="checkbox"/> Foot 8. <input type="checkbox"/> Trunk 17. <input type="checkbox"/> Toe 9. <input type="checkbox"/> Arm 18. <input type="checkbox"/> Hip	Type of Injury (check) 1. <input type="checkbox"/> Reaction to foreign substance/objects 2. <input type="checkbox"/> Puncture 3. <input type="checkbox"/> Laceration 4. <input type="checkbox"/> Confusion 5. <input type="checkbox"/> Burn 6. <input type="checkbox"/> Fracture 7. <input type="checkbox"/> Amputation 8. <input type="checkbox"/> Sprain/Strain 9. <input type="checkbox"/> Other	Name of Witness / Dept / Phone # 1. 2. 3.
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Instructor's / Reporting Party Name	Title	Date	Extension
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Contact Information

Department Head Signature (if injured is a student)	Title	Date	Extension
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Contact Information