University of the Pacific

INCIDENT ONLY / INJURY-ACCIDENT REPORT

EMPLOYEE NAME: _____

EMPLOYEE ID #:_____ DATE OF HIRE:_____

DATE OF INCIDENT OR INJURY:_____ DEPARTMENT:_____

TIME OF INCIDENT OR INJURY:_____ AM / PM SUPERVISOR:_____

DESCRIBE INJURY OR ILLNESS, INCLUDE ALL CIRCUMSTANCES CONTRIBUTING TO THE INJURY (Please be specific):

_____

_____

_____

_____

_____

LIST EQUIPMENT USED WHEN ACCIDENT OCCURRED: _____

LIST PERSONAL PROTECTIVE GEAR USED WHEN ACCIDENT OCCURRED: _____

BRIEFLY DESCRIBE FIRST–AID TREATMENT (if applicable):

_____

_____

EMPLOYEE SIGNATURE:_____ DATE: _____

FOR HR USE ONLY:

REPORT SENT TO ENVIRONMENTAL HEALTH AND SAFETY: _____
Date

☐ OCCUPATIONAL INJURY CLINIC / PERSONAL PHYSICIAN DATE: _____

☐ INCIDENT ONLY / NO TREATMENT REQUESTED OR REQUIRED – NO AOE/ COE DISPUTE

☐ FIRST AID TREATMENT PROVIDED – NO AOE/ COE DISPUTE

FOR ENVIRONMENTAL HEALTH AND SAFETY USE ONLY:

FOLLOW-UP REQUIRED: YES ☐

NO ☐

DESCRIPTION:

_____

_____

_____

_____

REPORT RETURNED TO HR: _____
Date