



INJURY / INCIDENT REPORT

Last Name		First Name(s)		
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone Number or Extension	Status <input type="checkbox"/> Full Time UW Employee <input type="checkbox"/> Part Time UW Employee <input type="checkbox"/> Graduate Research Assistantship Were you a UW employee at time of injury/incident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Student ID# _____ <input type="checkbox"/> Contractor <input type="checkbox"/> Visitor		
Department/Faculty		Occupation		Name of Person Completing This Form
Date and Time of Injury/Incident Day Month Year <input type="checkbox"/> am <input type="checkbox"/> pm		Date and Time Reported Day Month Year <input type="checkbox"/> am <input type="checkbox"/> pm		Injury/Incident Reported To
Injury Treatment (specify location and name of health care provider)				
<input type="checkbox"/> None <input type="checkbox"/> UW Health Services _____ <input type="checkbox"/> Family Physician _____ <input type="checkbox"/> Chiropractor _____ <input type="checkbox"/> Dept. First Aid <input type="checkbox"/> Walk-in Clinic _____ <input type="checkbox"/> Hospital _____ <input type="checkbox"/> Other _____				
Injury/incident location (building, room #, parking lot, etc.).				
What happened to cause the injury/incident?				
Explain what you were doing and the effort involved.				
Identify the size, weight and type of equipment or materials involved.				
What conditions and/or actions contributed to the injury/incident?				
Body part(s) involved (specify right or left side).				
Names and phone number of witnesses.				
Action taken by self/department to prevent recurrence. <input type="checkbox"/> Review job procedure and instruction <input type="checkbox"/> Personal Protective Equipment <input type="checkbox"/> Repair or replace equipment/facilities <input type="checkbox"/> Other _____ <input type="checkbox"/> Report unsafe conditions to Plant Operations(x33793) Explain				

Is there lost time from work due to this injury/incident? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" complete this section.				
Date and Time Last Worked Day Month Year <input type="checkbox"/> am <input type="checkbox"/> pm	Working Hours for Last Day Worked	Working Hours for Week of Injury Sun Mon Tues Wed Thurs Fri Sat	Total Hours Per Week	Date Returned To Work

Injured Person's Signature	Supervisor/Department Signature	Extension
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Forward within 1 day to Safety Office, Commissary Room 105 or Fax #519-886-8082. If completion is delayed, contact the Safety Office at ext. 33587 to make a preliminary report. Retain copies for departmental records.
 Information collected under the authority of the Occupational Health & Safety Act, Workplace Safety & Insurance Act and UW Policy #34 Health, Safety & Environment.