



Alabama Agricultural and Mechanical University Office of Human Resources

Mailing Address: Human Resources, Alabama A&M University, Normal, AL 35762
Phone: 256.372.5835 Fax: 256.372.5881

Workplace Injury or Illness Incident Report

1. Full Name of Injured _____ Telephone No. (____) _____
2. Address _____
Street City State Zip
3. Date of Birth ____/____/____ Department _____
4. Gender ____ Male or ____ Female
5. Date Hired ____/____/____
6. Date of accident/injury ____/____/____ Time of accident/injury _____
7. Date reported ____/____/____ Person to whom accident /injury was reported _____
8. Where did the accident, injury or exposure occur? _____
9. How did the accident/injury occur? _____

10. List any tools, equipment, substances, machinery, etc. in use when the event occurred _____

11. Describe the nature and severity of the injury. What part of the body was affected and how it was affected; be more specific than "hurt", "pain", or "sore." *Examples:* "strained back"; "chemical burn, hand"; and "carpal tunnel syndrome." _____

12. What object or substance directly harmed the employee? *Examples:* "concrete floor"; "chlorine"; "radial arm saw." If this question does not apply to the accident, then please write Not Applicable. _____

13. What happened? Tell us how the injury occurred. *Examples:* "When ladder slipped on wet floor, employee fell 20 feet"; "Worker was sprayed with chlorine when gasket broke during replacement"; or "Worker developed soreness in wrist over time." _____

14. What was the employee doing just before the incident occurred? Describe the activity, as well as the tools, equipment, or material the employee was using. Be specific. *Examples:* "climbing a ladder while carrying roofing materials"; "spraying chlorine from hand sprayer"; or "daily computer key-entry."

15. Did the injury/accident involve exposure to blood borne pathogens (bodily fluids)?

Yes No

16. Was the injury/accident witnessed?

Yes No

If yes, name(s) address(es), phone number(s) of witness(es): _____

17. Time injured employee reported to work on the day of incident. _____

18. Did the injured receive medical treatment? Yes No When? _____

19. If treatment was provided, state the name, address and phone number of the hospital or physician treating the individual. _____

20. Was the injured transported to: Physician Hospital Ambulance Self Another Person

21. If transported by another person or ambulance, give name, address and phone number of individual or list ambulance service. _____

22. Was an Incident Report filed with Campus Police? Yes No

23. Was the injured employee treated in an emergency room? Yes No

24. Was the injured employee hospitalized overnight as an in-patient? Yes No

25. How long was the injured employee off work due to the incident or will be off? _____

26. Has the employee returned to work? Yes No

27. If the employee died, when did death occur? ____/____/____

Name of person completing this form (please print)

Signature

Title:

Date: