

**THE UNIVERSITY OF ALABAMA
DEPARTMENTAL REPORT OF AN ON-CAMPUS
STUDENT INJURY (NON-EMPLOYEE) INCIDENT**

This report is to be submitted by the student receiving the injury on The University of Alabama Property. The injured student must complete this incident report and return the entire form to Environmental Health and Safety, P.O. Box 870178, Tuscaloosa, AL 35487 or fax to 348-7773, no later than the end of the workday following the incident.

Name (Last, First, M.I.): _____ CWID#: _____

Campus Address: _____ City: _____ State: _____ Zip: _____

Permanent Address: _____ City: _____ State: _____ Zip: _____

Local Phone: _____ Home Phone: _____ Age: _____

Sex (Circle one): Male or Female Date of Birth: _____

Department Enrolled In: _____ Major: _____

Date of injury or accident (mo/day/yr): ____/____/____

Time of injury or accident: _____ am or pm (circle one) Is this a new injury? YES NO (circle one)

Did the injury occur on The University of Alabama property? YES NO (circle one)

Location of incident (Building & Room Number): _____

Name(s) and Phone #(s) of Witness (es): _____

Did the student receive medical treatment following this incident? YES NO (circle one)

Medical Facility (name, phone, and address): _____

Describe clearly how the incident occurred:

Describe the nature of the injury (indicate body part injured):

Did an unsafe act or unsafe condition contribute to the injury/incident reported above? Describe:

I certify the information I have furnished on this form is true, correct, and complete to the best of my knowledge. Furthermore, I understand the information I supplied may be audited by the University or its representatives. I authorize The University of Alabama Student Health Center to release information about this event to The Office of Environmental Health and Safety.

Signature of Injured Person _____

Date _____

Date of Treatment: _____ **Time of Treatment:** _____

Diagnosis or Comment of Physician Regarding the Injured Person:

Treatment:

Return to school? _____ Hospitalized? _____ Return for follow-up care on _____ Anticipated Days Off _____

Referred to _____ Date: _____

SIGNATURE OF ATTENDING PHYSICIAN

BELOW TO BE COMPLETED BY EHS (ALL ON-CAMPUS STUDENT INJURIES ARE REVIEWED BY EHS)

Reviewed By:	Date:	Recommendations Initiated By:	Date:
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