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