Benefit Services
Washington State University
Pullman, WA 99164-1024
Telephone 335-4589

Accidental Injury, Occupational Illness, Workplace Incident
INCIDENT REPORT

Complete all sections. See SAFETY POLICIES AND PROCEDURES MANUAL S25.20 for instructions. Also used to report property damage.

LAST NAME OF AFFECTED PARTY 1	FIRST NAME AND MIDDLE INITIAL 2	ADDRESS 3	WSU ID NO. 4	INCIDENT DATE 5
DEPARTMENT AND COLLEGE/DIVISION 6			SEX 7 ☐ M ☐ F	DATE OF BIRTH 8
NAME OF PREPARER 9	TITLE OF PREPARER 10	PREPARER TELEPHONE NUMBER 11	MAIL CODE 12	DATE PREPARED 13

Check if applicable to incident: 14
☐ ACCIDENTAL INJURY ☐ OCCUPATIONAL ILLNESS ☐ PROPERTY DAMAGE ☐ MOTOR VEHICLE ☐ WORKPLACE VIOLENCE

STATUS 15 ☐ STUDENT ☐ VOLUNTEER ☐ VISITOR ☐ EMPLOYEE		JOB TITLE IF EMPLOYEE 16		DATE OF HIRE 17
HRS/DAY EMPLOYED 18	DAYS/WK EMPLOYED 19	SCHEDULED DAYS OFF 20	RATE OF PAY 21 PER ☐ MO ☐ HR	
TIME EMPLOYEE STARTED WORK 22 ☐ AM ☐ PM		TIME OF INCIDENT 23 ☐ AM ☐ PM		CHECK IF TIME CAN'T BE DETERMINED 24 ☐
NAME OF SUPERVISOR 25	TELEPHONE NUMBER 26	SUPERVISOR WAS NOTIFIED 27 DATE TIME ☐ AM ☐ PM		

COMPLETE DESCRIPTION OF WHAT THE PARTY WAS DOING JUST BEFORE THE INCIDENT OCCURRED (Example: Climbing ladder while carrying roof materials.) 28

COMPLETE DESCRIPTION OF INCIDENT, INCLUDE SPECIFIC ACTIVITY DURING INCIDENT (LIFTING, PUSHING, ETC.) (Example: When ladder slipped on wet floor, worker fell 20 ft.) 29

SPECIFY INJURY OR ILLNESS AND BODY PARTS AFFECTED (Example: Strained back) 30

DESCRIBE THE OBJECT OR SUBSTANCE THAT DIRECTLY HARMED THE PARTY (Example: Concrete floor) 31

EXACT LOCATION OF INCIDENT (BUILDING, FLOOR, GEOGRAPHICAL LOCATION) 32

NAMES AND PHONE NUMBERS OF WITNESSES OR OTHERS INVOLVED IN INCIDENT (Attach Witness/Injured Person Statements. See S25.25.5.) 33

INJURY/ILLNESS SEVERITY (See S25.20.4-5.) 34

☐ FIRST AID OR MEDICAL TREATMENT (Check all that apply)

____Use of bandages (e.g., butterfly bandages, Steri-Strips); ____Nonrigid braces and wraps; ____Finger guards; ____Eye patches; ____Removal of splinters with tweezers;
____Cleaning, flushing, or soaking surface wounds; ____Simple irrigations to flush foreign bodies from the eye; ____Tetanus shots; ____X-rays; ____Blood tests;
____Prescription medications*; ____Sutures, staples*; ____Casts, rigid braces*; ____Physical therapy*; ____Chiropractic treatment*; ____Surgery*; ____Other.

** This treatment is considered to be a medical treatment. If medical treatment is involved, supervisor must complete a Supervisor's Accident Investigation Report. See SPPM S25.25.*

☐ NO TREATMENT REQUIRED ☐ FATALITY, ENTER DATE:

TIME LOSS (Check all that apply.) 35

☐ RETURN TO WORK THE NEXT DAY ☐ RESTRICTED ACTIVITY/JOB TRANSFER (See S25.20.5-6.) BEGIN DATE: RETURN DATE:

☐ NO TIME LOSS ☐ LOST WORKDAYS, NOT AT WORK** (See S25.20.6.) BEGIN DATE: RETURN DATE:

*** If absent for the next full shift or subsequent shifts, supervisor must complete Supervisor's Accident Report and send a copy of employee's Time/Leave Report to Benefit Services.*

WORKDAY PHASE 36

☐ PERFORMING WORK ☐ MEAL PERIOD ☐ REST PERIOD ☐ ENTERING/LEAVING ☐ CHRONIC EXPOSURE ☐ OTHER, SPECIFY:

NAME AND ADDRESS OF MEDICAL PROVIDER (HOSPITAL, DOCTOR, CLINIC, ETC.) 37	TREATED IN EMERGENCY ROOM? 38 ☐ YES ☐ NO
	HOSPITALIZED OVERNIGHT AS INPATIENT? 39 ☐ YES ☐ NO

SIGNATURE OF INVESTIGATING SUPERVISOR DATE 40	SIGNATURE OF CHAIR/DEAN DATE 41
X	X

Route original and one copy to Benefit Services (campus mail code 1024) within 24 hours.
Route one copy to the departmental safety committee. Route one copy to the employee/student.

EH&S OFFICE USE ONLY	CASE NUMBER	☐ RECORDABLE ☐ NONRECORDABLE

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