

Student Accident/Injury Report

Name		Social Security/SBU ID	
Address		City/State	Zip
Home Telephone			
Date of Birth		Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	
Date of Accident		Time of Accident <input type="checkbox"/> AM <input type="checkbox"/> PM	
Place of Accident (be specific)		Work Location	
Type of Injury (e.g., cut, sprain, chem. splash)		Body Part Injured	
Medical Attention Required: <input type="checkbox"/> YES <input type="checkbox"/> NO		Seen By: <input type="checkbox"/> Private MD <input type="checkbox"/> Hospital ED <input type="checkbox"/> Other:	
Medical Name		Address	
Describe how accident occurred:			
Student Signature		Date	
Eyewitness Statement:			
Eyewitness Name (print)	Eyewitness Signature	Date	
Supervisor's Statement:			
What do you think can be done to prevent this from reoccurring?			
Was Parent/Guardian Called: <input type="checkbox"/> Yes – spoke with person - Name:			
<input type="checkbox"/> Left Message - Date:		Time:	
<input type="checkbox"/> No. Was not able to reach anyone.			
Supervisor's Name (print)	Supervisor's Signature	Date	

THIS FORM MUST BE COMPLETED AND SENT TO EH&S WITHIN 3 DAYS OF THE ACCIDENT/INJURY
Send copy of form to Environmental Health & Safety FAX: 632-9683 or Zip=6200