SOUTHERN ILLINOIS UNIVERSITY EDWARDSVILLE

Emergency Management & Safety
Campus Box 1657
http://www.siue.edu/emergencymanagement/
(618) 650-3584 Fax (618) 650-2196

_____
Case Number

Report of Injury

It is the responsibility of each supervisor to ensure that this report is filed with Emergency Management & Safety within 24 business hours of becoming aware of an incident or hazard related to SIUE facilities or operations.

Please complete only those sections that are applicable to the incident.

I. PERSON INVOLVED IN INCIDENT	**Name** (Last, First, Mi)	**Sex** ☐ F ☐ M	**E-Mail**
	Date of Birth		**Cougar ID #:**
	Address (Local)		**Phone** (W) _____ _____ _____ (H) _____ _____ _____
	Status At Time Of Incident ☐ Employee ☐ Visitor ☐ Student ☐ Other (Specify):	**If An Employee**, Give Job Title And Department	**If A Visitor**, State Purpose Of Campus Visit
	IF OTHERS WERE INVOLVED, ATTACH ADDITIONAL COPIES OF THIS FORM FOR EACH PERSON.		
	Were the Police Notified? ☐ Yes ☐ No Did Incident Arise Out Of And In The Course Of University Employment? ☐ Yes ☐ No		
II. INCIDENT/ OR HAZARD DESCRIPTION	**Place** Where Accident/Incident Occurred Or Hazard Is Located	**Date & Time** Of Incident	**Name Of Area Supervisor** Where Incident Occurred Or Hazard Is Located.
	Describe Activity Being Performed By Person Involved In Incident (I.E. Driving Truck, Lifting Crate, Etc.)		
	Fully Describe Incident/Hazard (Attach Additional Sheets If Necessary.)		
	List Any Witness Present Name	Address	Phone (W) ____ ___ _____
	Additional Witness(es) Present Name	Address	Phone (W) ____ ___ _____
III. INJURY	Did This Incident Result In Injury To The Person Involved? ☐ Yes ☐ No		
	If injury or illness results from an incident arising out of and in the course of university employment, the injured person or their supervisor (if injured person is unable) should call Tayanna Crowder in Human Resources at (618) 650-2190 if you wish to open a Worker's Compensation claim.		
	Describe Nature And Scope Of Personal Injury, If Any _____ _____ **Was Medical Care Sought**? ☐ No ☐ Yes: Place & Date of Treatment		
IV. PROPERTY DAMAGE	**Describe Property Damage**, If Any		
V. SIGNATURE	**Printed Name** Of Person Completing Form		**Job Title/Occupation**
	_____ _____ **Signature** Of Person Completing Form Date		**Phone Number** (W) _____ _____ _____ (H)

Original To: Emergency Management & Safety
Copy To: According to Individual Departmental Policy